

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01358									
CERTIFICATE OF DEATH									
01354									
1. DECEASED-NAME (Type or print) First Middle Last GLENN ARDELL ABBOTT					2a. DATE OF DEATH Month Day Year Jan 15 68			2b. HOUR 1:40 M	
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH 27 Apr 1917		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Okl.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Andrews AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAFH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY AF Ret.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince George			13c. CITY OR TOWN CampSpring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6005 Allentown Rd			14. FATHER'S NAME First Middle Last J. H. Abbott			15. MOTHER'S MAIDEN NAME First Middle Last Emma Kimmure			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1939-1964			16b. SOCIAL SECURITY NO. 552-16-8081		17. INFORMANT Wife Address Valea Abbott Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 1950 DUE TO, OR AS A CONSEQUENCE OF General Emaciation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1972 (b) Abdominal Malignancy with metastases (c) 3 Months								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Min. 1 Month 3 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 1 Jan 1968 , to 15 Jan 1968 , that (X) (we) last saw the deceased alive on 15 Jan 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John W. Bristow M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 15 Jan 68				
22d. PHYSICIAN'S NAME (Type) JOHN W. BRISTOW CAPT USAF					22e. ADDRESS Malcolm Grow USAF Hosp Andrews				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-18-1968		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery			23d. LOCATION (City or Town) (County) (State) New Philadelphia Penna.		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland					25a. REC'D BY REGISTRAR JAN 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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UNITED STATES
DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C.

MEMORANDUM FOR THE CHIEF OF STAFF
SUBJECT: [Illegible]

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1932

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01355					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First William			Middle Henry			Last Allen			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-4-68 19 4:00p M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 14 May 1920		6. AGE (In years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month 1 Day 4 Year 68 19 5:11p M			
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.						
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Gen. Hospital						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince George's			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 7410 Booker Drive						
14. FATHER'S NAME First Middle Last William H. Allen, Deceased			15. MOTHER'S MAIDEN NAME First Middle Last Laura Tyler			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes						16b. SOCIAL SECURITY NO. 578-16-3523		17. INFORMANT Cleo Allen 7410 Booker Dr. St. Pleasant, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> 5718 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF over 4 yrs. (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County		State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 1-5-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-8-68		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION (City or Town) (County) (State) Prince George, Maryland			25b. REGISTRAR'S SIGNATURE Charles Judge				
24. FUNERAL DIRECTOR Rhens Funeral Home			25a. REC'D BY REGISTRAR DATE JAN 15 1968												

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

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01360

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01357

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Cora Elizabeth Armstrong						Month Day Year			1-10-68 192:00p M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	7-7-1893	74 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			50p M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Md		USA		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Laurel			106 Spruce Street			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md. Prince George			Laurel			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			106 Spruce Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
William Thaman Shaffer			Elizabeth Ann Jones								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no						John G Armstrong Laurel Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH CAUSED BY:											
IMMEDIATE CAUSE (a) Heart failure										minutes	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
4200											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			1-11-68					
John Kehoe, M.D. Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1-13-68		Emmanuel Cem		Scaggsville Md					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Dr Witt Canadian Laurel Md				DATE JAN 22 1968				Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01352

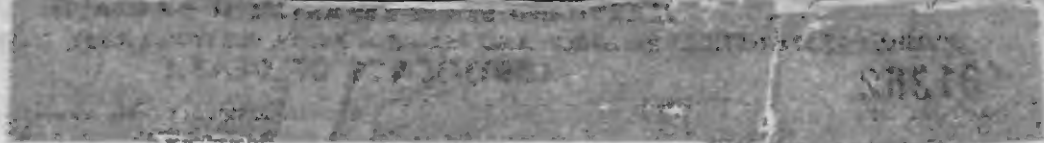
01358

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN 1b <u>10 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel (rural)</u> d. STREET ADDRESS <u>735 Washington B lvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES GATOR ARTHUR</u>		4. DATE OF DEATH Month Day Year <u>January 10 1968</u>		5. SEX <u>male</u>					
6. COLOR OR RACE <u>caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>22 September 1909</u>					
9. AGE (In years last birthday) <u>58</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainer of horses</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Horse Racing</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months Days	Hours Min.								
11. BIRTHPLACE (County & State, or foreign country) <u>GREENUP ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK ARTHUR</u>					
14. MOTHER'S MAIDEN NAME <u>JOSEPHINE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-32-6511</u>					
17. INFORMANT <u>HELEN R. ARTHUR</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute anterior myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>9 Jan 1968</u> to <u>10 Jan 1968</u> the (I) (we) last saw the deceased alive on <u>10 Jan 1968</u> and that death occurred at <u>Laurel, Md.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard Compton</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11 Jan 1968</u>					
22c. PHYSICIAN'S NAME (Type) <u>J. RICHARD COMPTON MD</u>		22d. ADDRESS <u>612 MAIN ST., LAUREL, MD</u>		22e. ADDRESS <u>550 WASH'N BVD. MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1/13/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CATHOLIC CEMETERY</u>					
23d. LOCATION (City, town, or county) (State) <u>LAUREL, PRINCE GEORGES, MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Jones</u>							
25a. REC'D BY REGISTRAR DATE <u>JAN 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

26510



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month Day Year		17. HOUR P M	
David		Louis		Appflebaum		Appflebaum		Jan. 26		1968		12:35	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
male		white		March 11, 1947		20 YRS.						Jan. 27 Year 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH					
New York		USA		WIDOWED		DIVORCED		Prince George's				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Camp Springs		Rt. 495											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
New York		Kings		Brooklyn, N.Y.		YES NO		1457 East 10th Street					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Robert Appflebaum		Harriette Pessin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
yes		At time of Death		076 36 7002		Bethesda Naval Hosp. Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest 965 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) 781 X													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES NO							
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year About 1:30PM 1-26-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot by assailant.									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Shoulder of road.		21f. LOCATION Street or R.F.D. No. City or Town County State Rt. 495 Camp Springs P.G. Md.									
22a. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner													
ACTUAL SIGNATURE		John Kehoe, M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		John Kehoe, M.D.		ADDRESS (Street, City, State, Zip)		Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Removal		1-28-68				Brooklyn, N.Y.							
24. FUNERAL DIRECTOR		FALLS CHURCH F.H. ADDRESS 1102 W. Broad		25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
David L. Szwed		FALLS CHURCH, VA.		DATE JAN 31 1968		Charles J. Jager							

01381

01381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

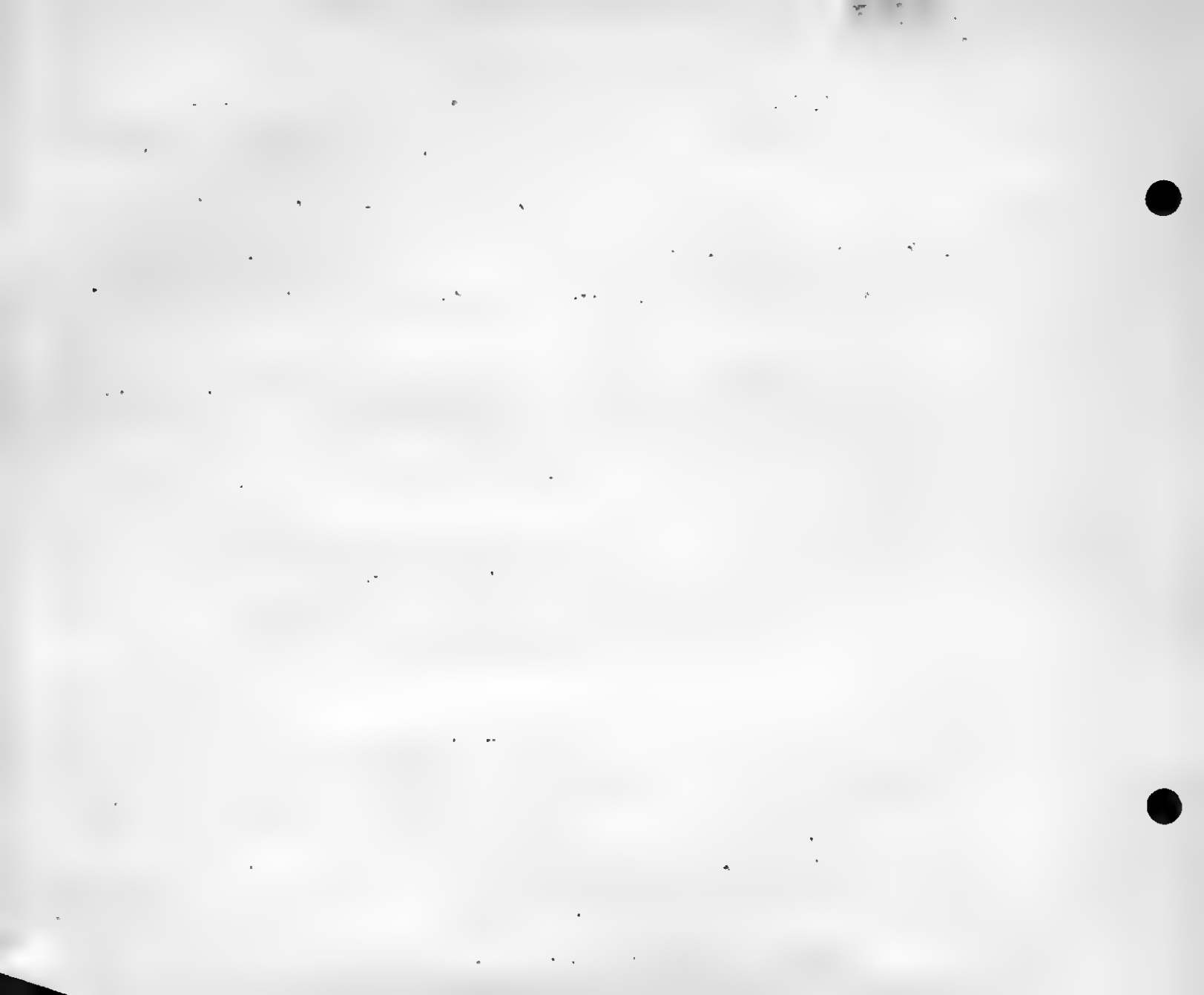
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01353 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 Film G397 1/24/68 kk

CERTIFICATE OF DEATH

01359

1 DECEASED NAME (Type or print) First Middle Last Viola Atkinson			2a DATE OF DEATH Month 1-8-88 Year		2b HOUR 11:10a
3 SEX female	4 RACE White	5 DATE OF BIRTH 4-14-07		6 AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) VA.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges, Md.		
10 CITY OR TOWN OF DEATH Riverdale, Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Prince Georges	13c CITY OR TOWN Beltsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 1227 Gun Powder Rd.					
14. FATHER'S NAME First Middle Last Robert James			15. MOTHER'S MAIDEN NAME First Middle Last Martha Bland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) no		16b. SOCIAL SECURITY NO.	17 INFORMANT Address Hospital records Riverdale, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GEN. ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS UNKNOWN					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 12-18, 1967, to 1-3, 1968, that (I) (we) last saw the deceased alive on 1-3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. J. Houtmann			DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 1-8-68
22d. PHYSICIAN'S NAME (Type) C. J. Houtmann			22e. ADDRESS RIVERDALE MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan 11, 1968	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar manor Pro Geo Md.	
24. FUNERAL DIRECTOR F Gasch's Sons			ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 15 1968
			25b. REGISTRAR'S SIGNATURE Nicholas Judge		



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01364

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2940

1. DECEASED-NAME (Type or print) Juanita Ruiz Baez			2a. DATE OF DEATH Jan Month 18 Day 68 Year			2b. HOUR P 8:10 M			
3 SEX Female		4 RACE Cauc		5 DATE OF BIRTH Jan 18 1968		6 AGE (In years last birthday) YRS		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN 1 57	
7a BIRTHPLACE (State or foreign country) Andrews AFB MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH Andrews AFB		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital add street address) Malcolm Grow USAF Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) n/a		12b KIND OF BUSINESS OR INDUSTRY n/a			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b RESIDENCE BEFORE (If institution residence before) Prince George		13c CITY OR TOWN Oxon Hill		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5160 Livingston Ter.	
14. FATHER'S NAME First Adrian Middle Baez Last Marino			15. MOTHER'S MAIDEN NAME First Mercedes Middle Ruiz Last de Baez						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT Address Father same as item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 7762 DUE TO, OR AS A CONSEQUENCE OF (b) to immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 55 mins.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 18 Jan , 19 68 , to 18 Jan , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 Jan , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b SIGNATURE Paul H. Penzer				DEGREE CAPT USAF		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 18 Jan 68	
22d. PHYSICIAN'S NAME (Type) PAUL H. PENZER, CAPT USAF				22e. ADDRESS MALCOLM GROW USAF HSOP ANDREWS					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 23 Jan 68		23c. NAME OF CEMETERY OR CREMATORY PUBLIC		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.			
24. FUNERAL DIRECTOR Carl F. Cuyler				ADDRESS		25a. REC'D BY REGISTRAR FEB 13 1968		25b. REGISTRAR'S SIGNATURE	

Car. & P. 1894

01355

CERTIFICATE OF DEATH

01360

1. DECEASED NAME (Type or print) <u>ETHEL A BALDWIN</u>			2a. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1968</u>			2b. HOUR <u>7:30</u> AM	
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>May 14 1888</u>		6. AGE (In years last birthday) <u>79</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md	
10. CITY OR TOWN OF DEATH <u>Hyattsville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Elizabeth's Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>Landover</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>606 Prince George's</u>							
14. FATHER'S NAME First <u>John</u> Middle <u>Lee</u> Last <u>Thompson</u>			15. MOTHER'S MAIDEN NAME First <u>Archie</u> Middle <u>L</u> Last <u>Pickett</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <u>no</u>		16b. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>H. A. Elder</u> Address <u>606 Prince George's St. Landover, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>431.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>T. H. Elder</u>				DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/15/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>T. H. Elder</u>		22e. ADDRESS <u>13011 MISTLETOE SPRING RD. LAUREL, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-10-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Longview</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurel Md</u>	
24. FUNERAL DIRECTOR <u>William D. ...</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01366

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

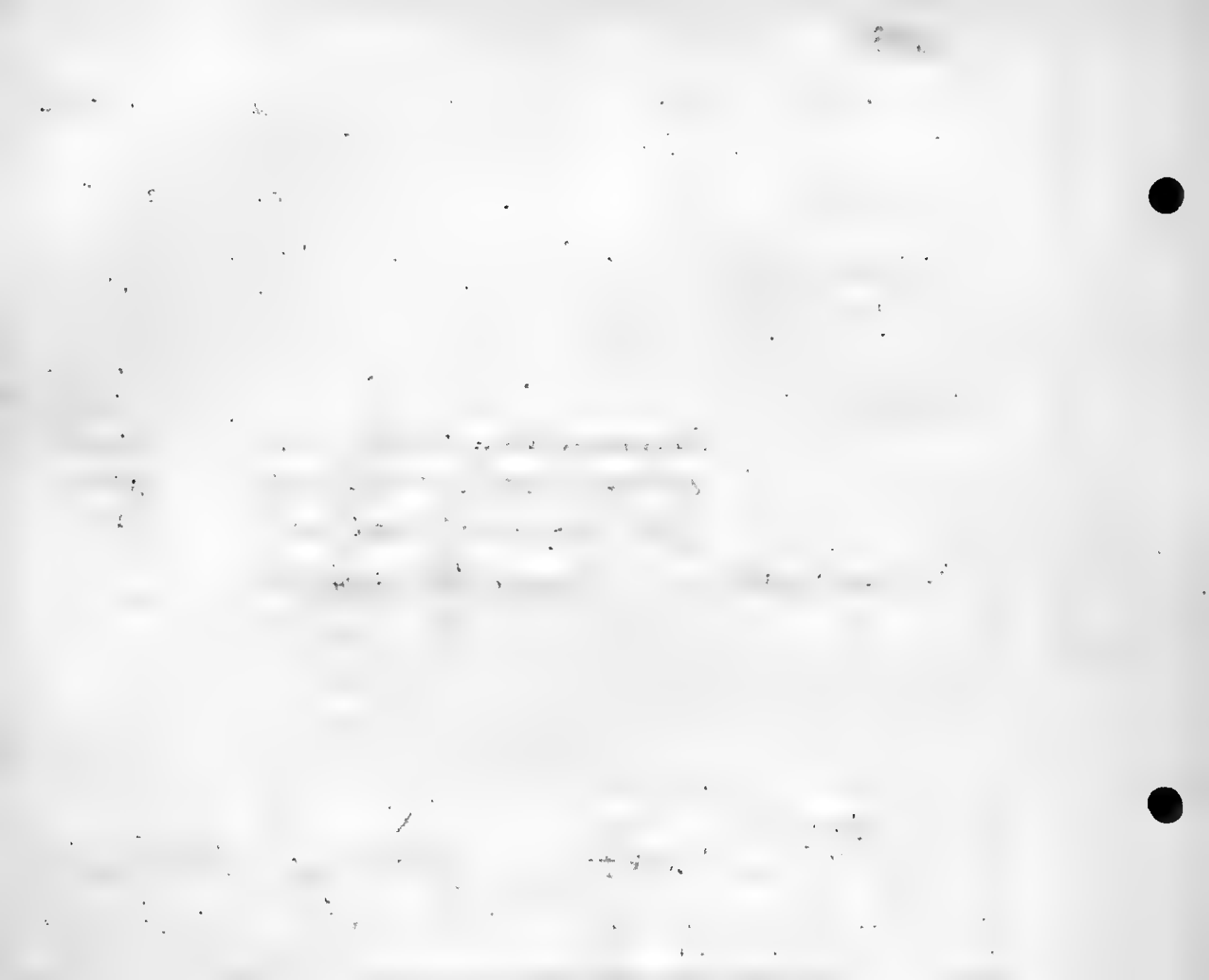
01361

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Rose Marie Ball						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 1-6-68			19 5:00am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	Negro		27 YRS					1 Month 6 Day 68 1982			00am M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
						Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Landover			Wooded Area, Landover								
13a USUAL RESIDENCE (Where deceased lived, if institution residence, before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY - HUNTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
District of Columbia			Washington						13e STREET AND NUMBER		
									1503 7th St., N.W.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 1-6-68 9 P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Unknown			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) unknown				21f LOCATION Street or R.F.D. No City or Town County State			
								unknown			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 1-8-68			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a BURIAL (CREMATION) REMOVAL (Specify)			23b DATE 1-19-68			23c NAME OF CEMETERY OR CREMATORY AMT. BD. OF MD. UNIV. OF MD.			23d LOCATION (City or Town) (County) (State) BALTIMORE, Md.		
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR DATE JAN 22 1968			25b REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

01367		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01362	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) Annie Naomi Bankmann			2a. DATE OF DEATH Month Jan Day 13 Year 1968			2b. HOUR 9:30 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH June 18 1887		6. AGE (in years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3508 54th AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN CHEVERLY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3508 54th AVE.		14. FATHER'S NAME First HENDERSON Middle SANDERS Last SANDERS		15. MOTHER'S MAIDEN NAME First LAURENA Middle FOLLIN Last FOLLIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS HELEN B MATHEWS		Address SAME AS #73	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Branchopneumonia DUE TO, OR AS A CONSEQUENCE OF						1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4 (b) intermediate heart disease DUE TO, OR AS A CONSEQUENCE OF						years	
(c) generalized arteriosclerosis						year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus Chronic Pyelonephritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. James Kurtz MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) H. James Kurtz		22e. ADDRESS RFD Glenn Dale Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN 16 1968		23c. NAME OF CEMETERY OR CREMATORY ARMON CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT FALLS, VIRGINIA	
24. FUNERAL DIRECTOR W.W. CHAMBERS & CO.		ADDRESS RIVERDALE, MD		25a. REC'D BY REGISTRAR JAN 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

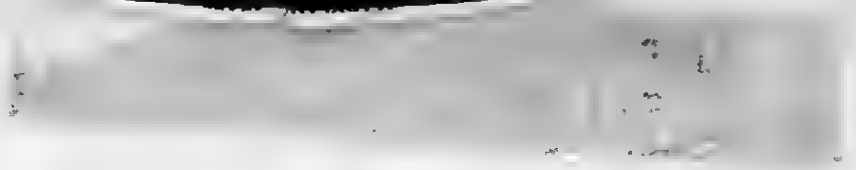


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
01363											
1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institut an: Residence before adm ssion) a STATE Washington, D. C. b COUNTY					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c LENGTH OF STAY IN 1b 2 yrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital						d STREET ADDRESS 217 Varnum St., N. W.				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Emma Middle R. Last Banks						4 DATE OF DEATH Month 1 Day 20 Year 19 68					
5 SEX F		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 11/29/1903		9 AGE (In years last birthday) yrs 64		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper?				10b KIND OF BUSINESS OR INDUSTRY --		11 BIRTHPLACE (County & State, or foreign country) Washington, D. C.				12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Banks						14. MOTHER'S MAIDEN NAME Lelia Moss					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16 SOCIAL SECURITY NO. unknown		17. INFORMANT Decedent Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accidents with left hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Generalized arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive and arteriosclerotic cardiovascular disease											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/25/ , 19 66 , to 1/20/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/20/ 19 68 , and that death occurred at 7:45 AM , from causes and on the date stated above.											
22a SIGNATURE Moe Weiss, M. D.						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 1/20/1968			
22c PHYSICIAN'S NAME (Type) Moe Weiss, M. D.						22d ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-25-68		23c. NAME OF CEMETERY OR CREMATORY LINCOLN CEMETERY				23d LOCATION (City or town) (County) (State) SUITLAND, MD.			
24 FUNERAL DIRECTOR BARNES & MATTHEWS, Inc.				ADDRESS 3619 - 14 ST. N.W.		25a REC'D BY REGISTRAR JAN 25 1968		25b. REGISTRAR'S SIGNATURE John A. Judge			



1. The first part of the document is a list of names and addresses of the members of the committee.

2. The second part of the document is a list of names and addresses of the members of the committee.

3. The third part of the document is a list of names and addresses of the members of the committee.

4. The fourth part of the document is a list of names and addresses of the members of the committee.

5. The fifth part of the document is a list of names and addresses of the members of the committee.

6. The sixth part of the document is a list of names and addresses of the members of the committee.

7. The seventh part of the document is a list of names and addresses of the members of the committee.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

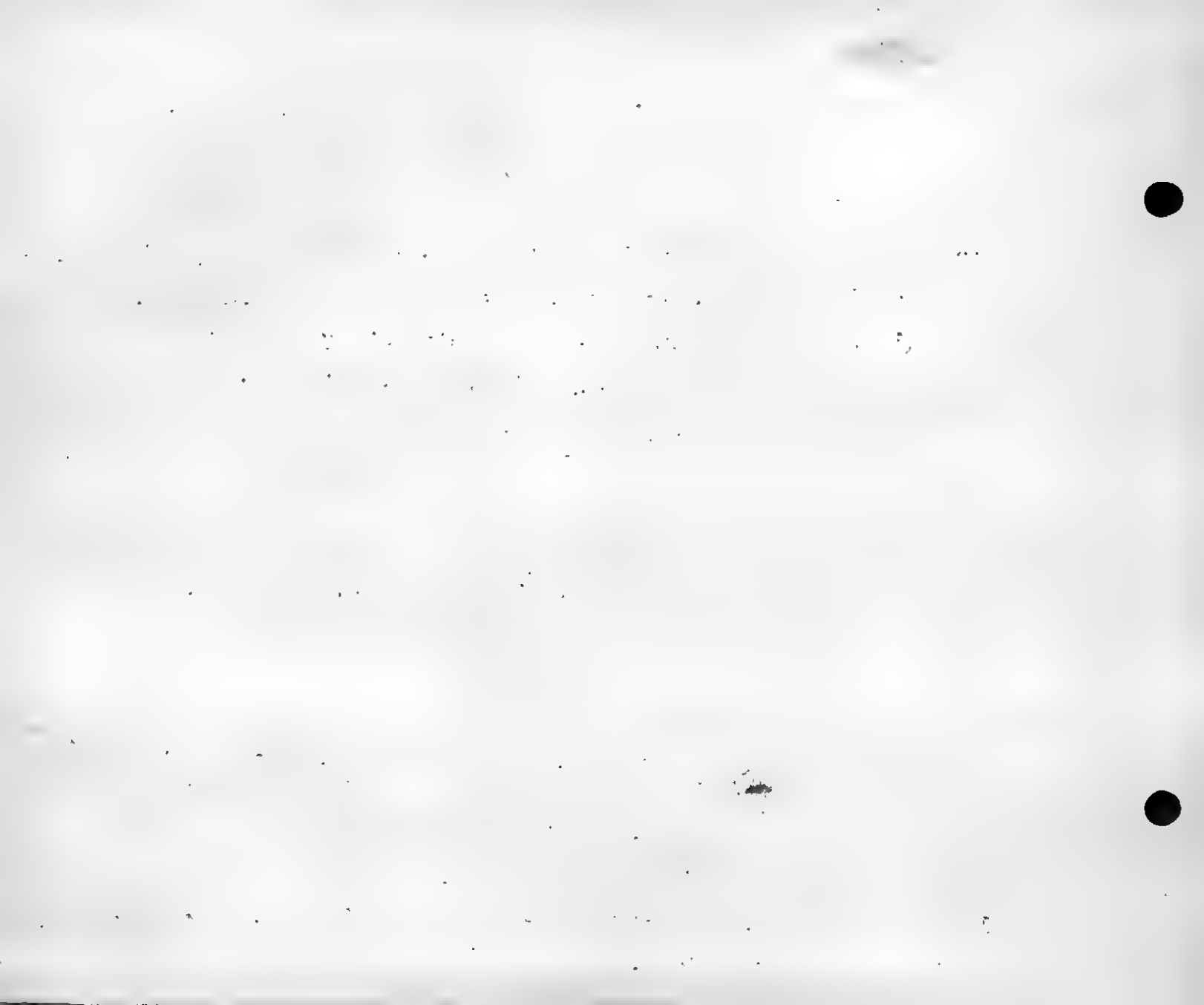
VR A15 (4)
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01369

01364

1 DECEASED-NAME (Type or print) John		First John		Middle E.		Last Barker		2a. DATE OF DEATH Month January Day 13 Year 1968			2b. HOUR 12:40 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 4/4/21		6 AGE (In years lost birthday) 46		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		
7a BIRTHPLACE (State or foreign country) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.						
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George's General H.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MOTOR MECHANIC		12b KIND OF BUSINESS OR INDUSTRY NAVY YARD, D.C.						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Pr. George's		13c CITY OR TOWN Riverdale		13d INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5011 Sheridan St.				
14. FATHER'S NAME First JAMES J. Middle J. Last BARKER		15 MOTHER'S MAIDEN NAME First HELEN B. Middle WRIGHT Last WRIGHT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-284300		17. INFORMANT BARBARA BARKER Address SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETIC ACIDOSIS & COMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 60X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PYELONEPHRITIS; OSTEOMYELITIS, RT LEG												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from JAN 9 , 19 68 , to January 13 , 19 68 , that (I) (we) last saw the deceased alive on JAN 13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Samuel J. N. Sugar MD		22c. DATE SIGNED Jan 14, 1968		22d. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR MD		22e ADDRESS 4637 EASTERN AVE WASH DC 20018						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE JAN. 17, 1968		23c NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND						
24 FUNERAL DIRECTOR W W Chambers Co., Inc.		24b ADDRESS 1400 CHAPIN N.W.		25a. REC'D BY REG. STRAR DATE JAN 18 1968		25b. REGISTRAR'S SIGNATURE Charles Jones						

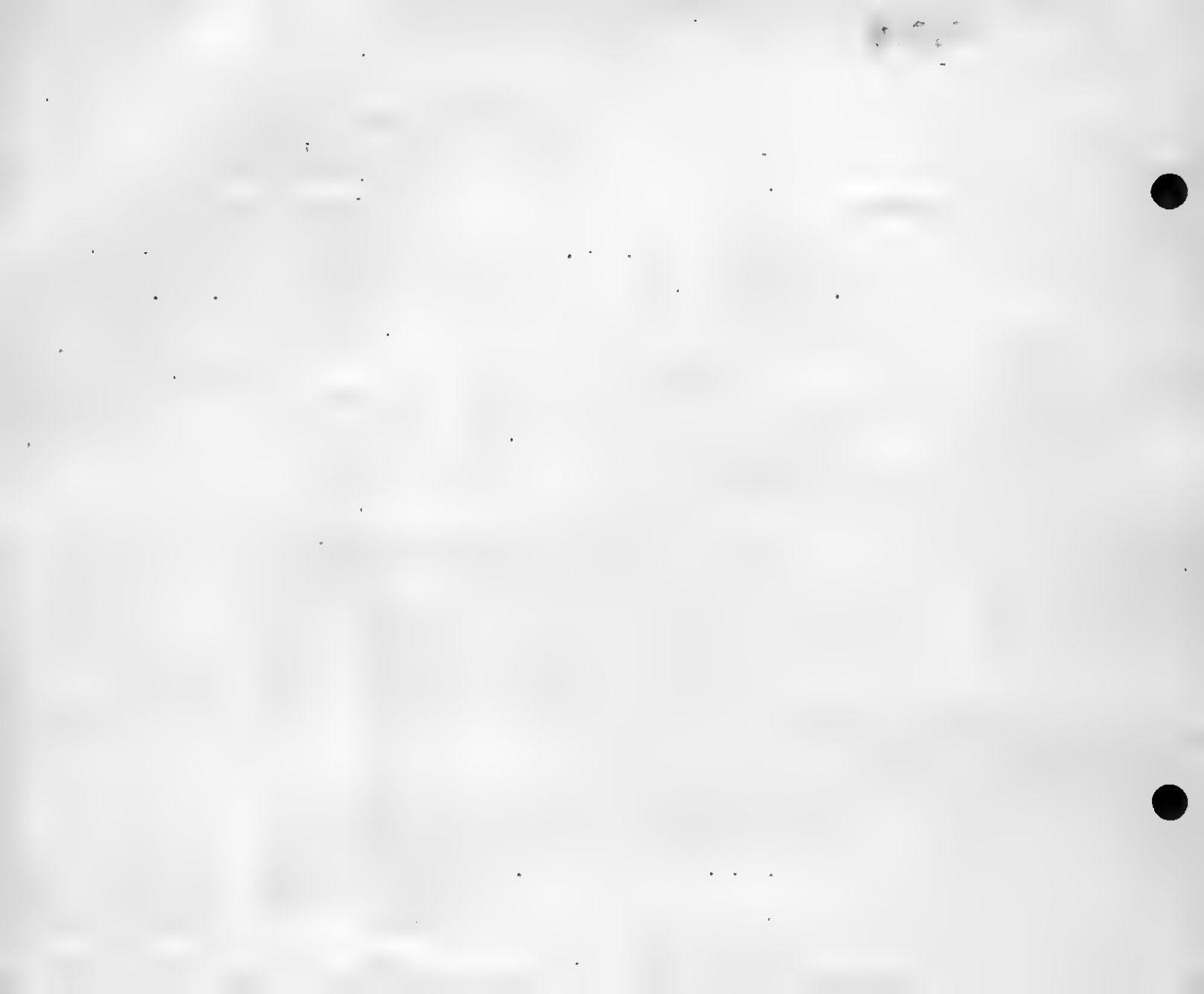


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

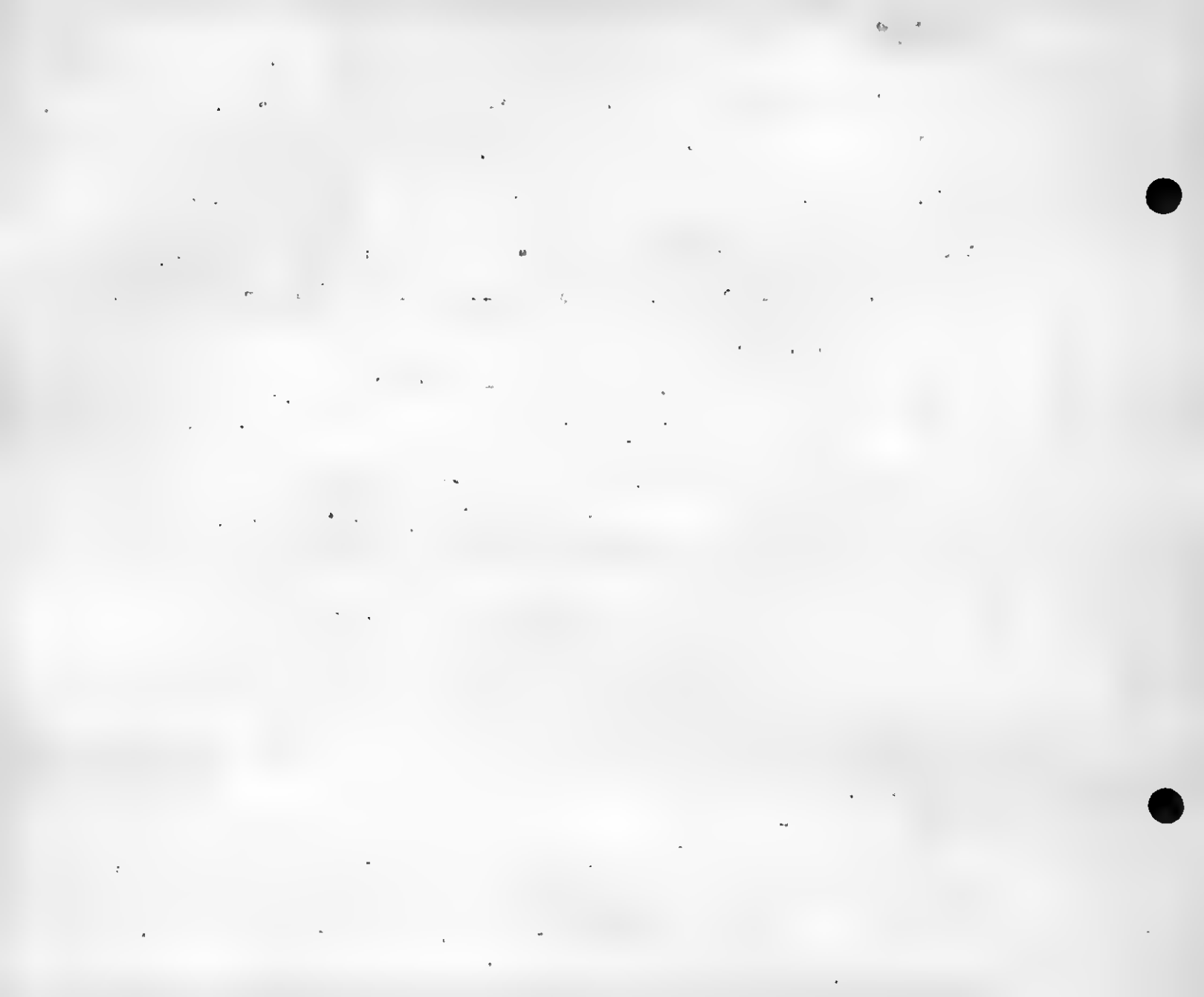
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Betty Laura Barnes						ESTIMATED <input checked="" type="checkbox"/> 1-5-68 19 3:00a M				
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		
Female	White	9-8-1919	48 YRS.					1 5 68 19 7:55a M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Nebraska		U S A				Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Hillcrest Heights			5204 27th. Ave.			Housewife		at home		
13a. USUAL RESIDENCE (Where deceased lived, if not in institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Prince George		Same as #10				5204 27th. Ave.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Peter Nielsen			Magda Tulin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
No			577.50.7512		Wm. T. Barnes		same as #11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Carcinoma of stomach										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on death resulted from: Not a cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held on			Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
John Kehoe, M.D. Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
			22b. DATE SIGNED 1-5-68							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			1.8.68		Cedar Hill Cemetery		Suitland Maryland			
24. FUNERAL DIRECTOR			ADDRESS				25a. RECEIVED BY REG. STRAR			
Lee Funeral Home			300.4th st N E Wash. D C				25b. REGISTRAR'S SIGNATURE			
			DATE JAN 8 1968				J. Charles Jones			



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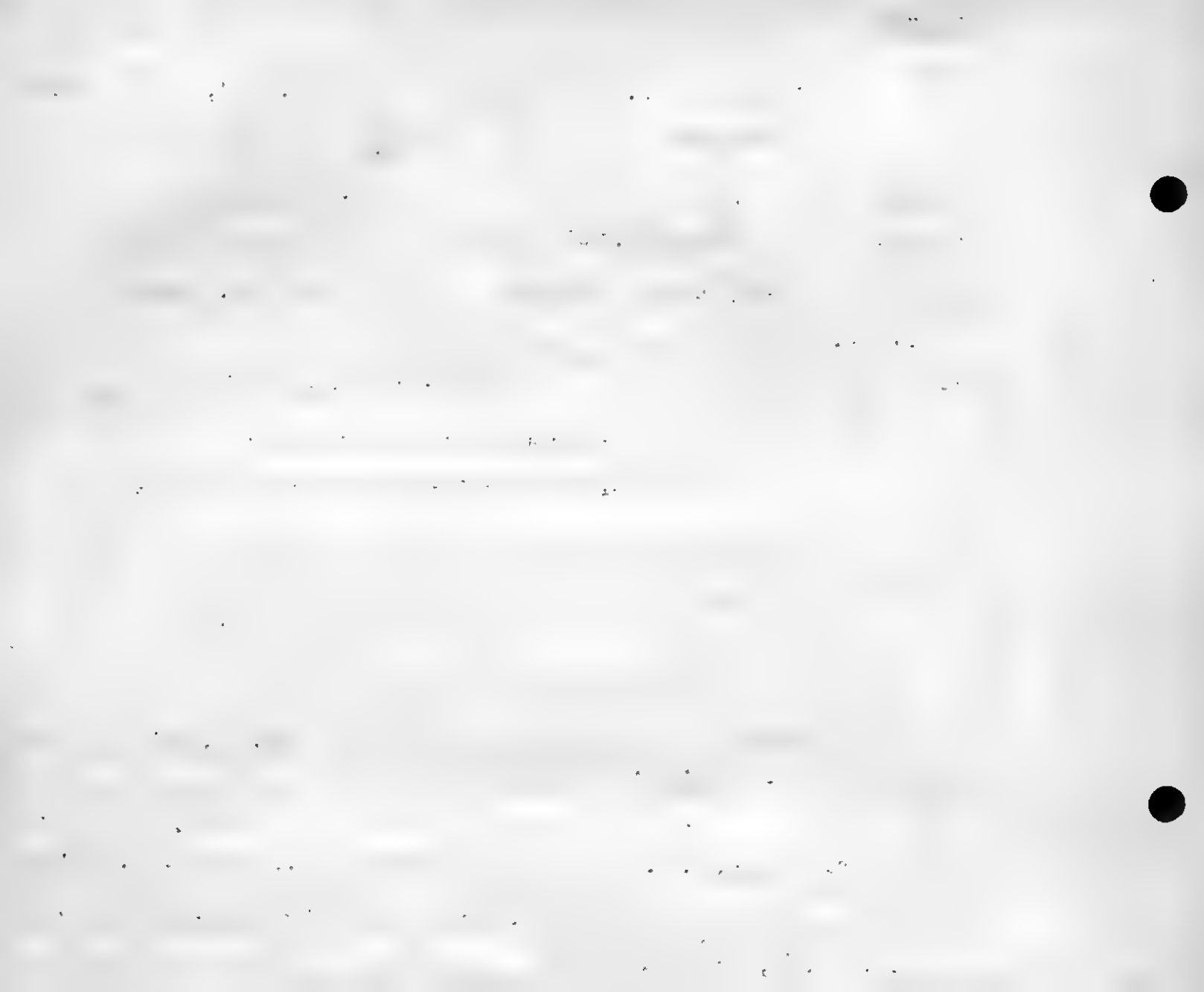
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Charles A. Barr						Jan 8 1968			1:15 PM
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR	
Male		White		2/11/97		70 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Prince Georges Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Riverdale			Eugene Leland Memorial			Retired butcher			Food store
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md. Prince Georges			Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6012-39th Avenue 20782		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Barr			Julia Lynch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			216 05 6059		Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Death Myocardial Infarction</i>									
DUE TO, OR AS A CONSEQUENCE OF <i>arterio sclerotic cardiac</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>vascular lesion</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
White <input type="checkbox"/> Not while at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>Jan 1968</i> , that (I) (we) lost the deceased alive on <i>1-1-68</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<i>W.L. Etienne</i>								<i>1-8-68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
W.L. ETIENNE		College Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan 10, 1968		Prospect Hill Cemetery		Washington D. C.			
24. FUNERAL DIRECTOR		F Gasch's Sons		Hyattsville, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						DATE JAN 12 1968		<i>Charles Judge</i>	



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	-Last	2a. DATE OF DEATH			2b. HOUR		
Wiley			K.	Beale	Jan. Month 17, Day 1968			3:15 P			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR			
Male		Caucasian		2/9/08		59 YRS		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Virginia		USA				Prince Georges Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR IND. STRY.			
Cheverly			Prince Geo. Gen'l Hospital			Produce Manager Safeway Stores					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM 157		13e STREET AND NUMBER		
Maryland			Prince Georges		Cheverly		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2701 Crest Avenue		
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME			First	Middle	Lost
Charles J. Beale						Anna Owens					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
YES			WW II			Violet Beale, wife, SAME AS # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Massive Pulmonary embolism of both lungs</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Uretero-lithiasis (22 days post operative status)</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a I certify that (I) (was hospital) attended the deceased from <u>Jan. 17, 1968</u> , to <u>Jan. 17, 1968</u> , that (I) (was) saw the deceased alive on <u>Jan. 17, 1968</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (not) view the body after death.											
22b SIGNATURE						DEGREE		ATTENDING PHYS		22c DATE SIGNED	
<u>Peter Duus</u>								<input checked="" type="checkbox"/>		Jan 17, 1968	
22d PHYSICIAN'S NAME (Type)						22e ADDRESS					
Peter Duus, M. D.						6124 Central Ave., Capitol Hgts. Maryland					
23a BURIAL, CREMATION, REMOVA (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial			1/20/68		Cedar Hill Crematory		Prince Georges, Maryland				
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland						JAN 22 1968		<u>James Judge</u>			



FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 743-3. 5 may be retained for your files.

UNUSUAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

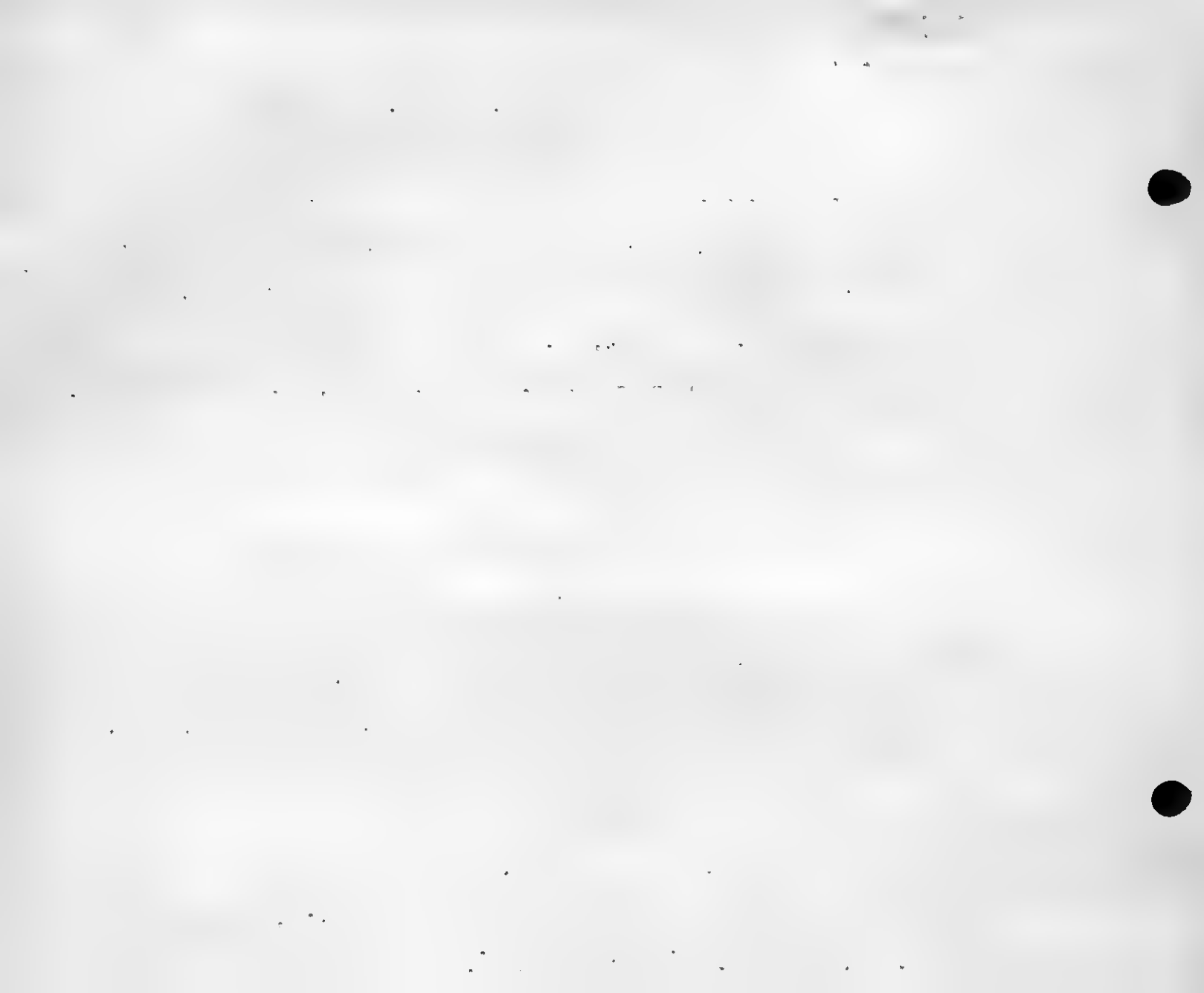
01373

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year				2b. HOUR	
George Washington Beatty Jr.						1-13-68				1:30am	
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	4-27-1934	33 YRS.					1 13 68		1:30am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Sharon, Penn.		U.S.A.				Prince George's Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Beland Memorial Hospital			Bricklayer			Bricklaying		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER		
Md.			Montgomery Takoma Park			YES <input type="checkbox"/> NO <input type="checkbox"/>			7122 Willow Avenue		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
George W. Beatty, Sr.			Isabell Henry								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT					
yes			577-44-2516			Mr. George W. Beatty, Sr. ADDRESS 7122 Willow Avenue Takoma Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Gun shot wound of abdomen</u> DUE TO, OR AS A CONSEQUENCE OF 765X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 1-13-1968 12:55am			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot by assailant.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Lee's Bar			21f. LOCATION Street or R.F.D. No City or Town County State 2903 Hamilton Street, Hyattsville, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			1-14-68		
John Kehoe, M.D.			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jan 19, 1968			Oakwood Cemetery			Sharon, Pennsylvania		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John Thomas			8434 Georgia Ave.			DATE JAN 22 1968			J. Charles Jones		
Warner E. Pumphrey, Inc.			Silver Spring, Md.								



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01374

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01369

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
Frank						Beavers, Jr.		<input checked="" type="checkbox"/> Month		1-19-68		19		5		05a M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		2d. HOUR	
Male	White	4-14-1929		38 YRS		MONTHS		DAYS		1		19		68		512a M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH									
Virginia		USA		WIDOWED		DIVORCED		Prince George's									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly		Prince George Hospital		Salesman		Doughnut											
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission, STATE)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Virginia		Fairfax		Alexandria		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2326 River view Terrace									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Frank						Beavers		Lena						Love			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
Yes		224-32-2111		Mrs. Delores Beavers		Alex., Va.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		Laceration of brain		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
212 A																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b)		DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)		8164															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
5:00am 1-19-68		Driver of car involved in collision															
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County		State							
Rt 495		1 mile south of Rt 50, Prince George County, Maryland															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		1-19-68					
EXAMINER'S NAME (Type)		John Kehoe, M.D.		ADDRESS (Street city, town or county)		Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		1/22/68		Mt Comfort		Fairfax Co., Virginia											
24. FUNERAL DIRECTOR		Cameron & Alfred Sts.		25a. REC'D BY REG STRAR		25b. REGISTERED SIGNATURE											
Walter S. Hall		Alex., Va.		JAN 25 1968													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

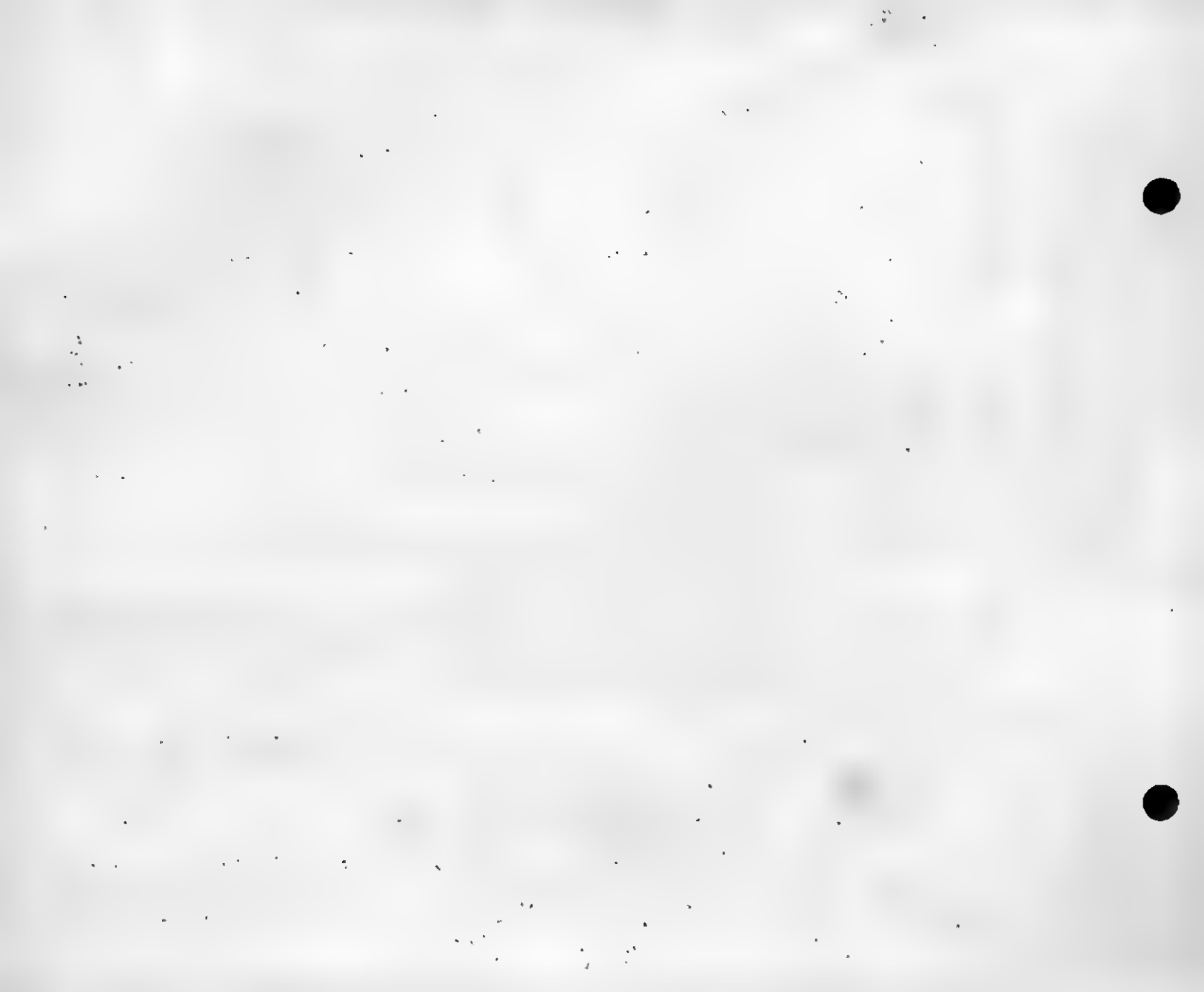
01375

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01370

1 DECEASED NAME (Type or print) <i>Gabrielle</i>			First Middle Last <i>Berkley</i>			2a. DATE OF DEATH Month Day Year <i>1 29 68</i>			2b. HOUR <i>8:50 AM</i>								
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8-5-73</i>			6. AGE (In years last birthday) <i>94</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.						
7a. BIRTHPLACE (State or foreign country) <i>France</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.											
10. CITY OR TOWN OF DEATH <i>Hyattsville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Manor</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Dressmaker</i>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>D.C.</i>			13b. COUNTY <i>Wash.</i>			13c. CITY OR TOWN <i>Wash.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1330 E. Capitol Street</i>							
14. FATHER'S NAME First Middle Last <i>Joseph Chaud</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Theresa ?</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Sr. M. Regis, D'Conn</i>					
16c. ADDRESS <i>4922 LaSalle Rd</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>11 years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) this hospital attended the deceased from <i>Dec. 1</i> , 19 <i>57</i> , to <i>Jan. 29</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>Jan. 28</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Thomas F Collins</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>1/29/68</i>								
22d. PHYSICIAN'S NAME (Type) <i>Thomas F Collins, M.D.</i>			22e. ADDRESS <i>322 H St. N.E. Washington, D.C.</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2-1-1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. X Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Wash. D.C.</i>								
24. FUNERAL DIRECTOR <i>Robert A. Hopting</i>			24a. ADDRESS <i>131-11 St. Wash. D.C.</i>			25a. REC'D BY REGISTRAR <i>DATE FEB 2 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01376										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01371									
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Edythe Berg										Jan. 3, 1968										5 P. M.									
3. SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			Caucasian			12/10/88			79 YRS			MONTHS			DAYS														
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH																				
Florida			U S A						Prince Georges Md																				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY																				
Cheverly			Prince Geo. Gen'l Hospital			Clerk			U S Government																				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER																	
Maryland			Calvert			North Beach						Box 177, North Beach																	
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME																								
Otto Hammerer					Emma ?																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no					16b SOCIAL SECURITY NO.					17 INFORMANT																			
										George O. Berg North Beach, Md.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastasis, Cancer of Uterine Cervix to lungs;</u>																													
DUE TO, OR AS A CONSEQUENCE OF <u>with pneumonia</u>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe stenosing coronary arteriosclerosis.</u>																													
DUE TO, OR AS A CONSEQUENCE OF (c) _____																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a DATE OF OPERATION															19b CONDITION FOR WHICH OPERATION WAS PERFORMED														
20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes														
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)															21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>															21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (the husband) attended the deceased from <u>Jan. 3, 1968</u> , to <u>Jan. 3, 1968</u> , that (I) (we) saw the deceased alive on <u>Jan. 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (diagnose) view the body after death.																													
22b. SIGNATURE <u>George Hageage</u>															22c. DATE SIGNED <u>1-4-68</u>														
22d. PHYSICIAN'S NAME (Type) <u>George Hageage, M. D.</u>															22e ADDRESS <u>3717 38th Ave., Cottage City, Maryland</u>														
23a BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Cremation					Jan 8, 1968					Ft Lincoln Crematory					Colmar Manor Pro Geo Md.														
24 FUNERAL DIRECTOR										25a REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
F. Gasch's Sons Hyattsville, Md.										DATE JAN 8 1968										Charles Judge									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

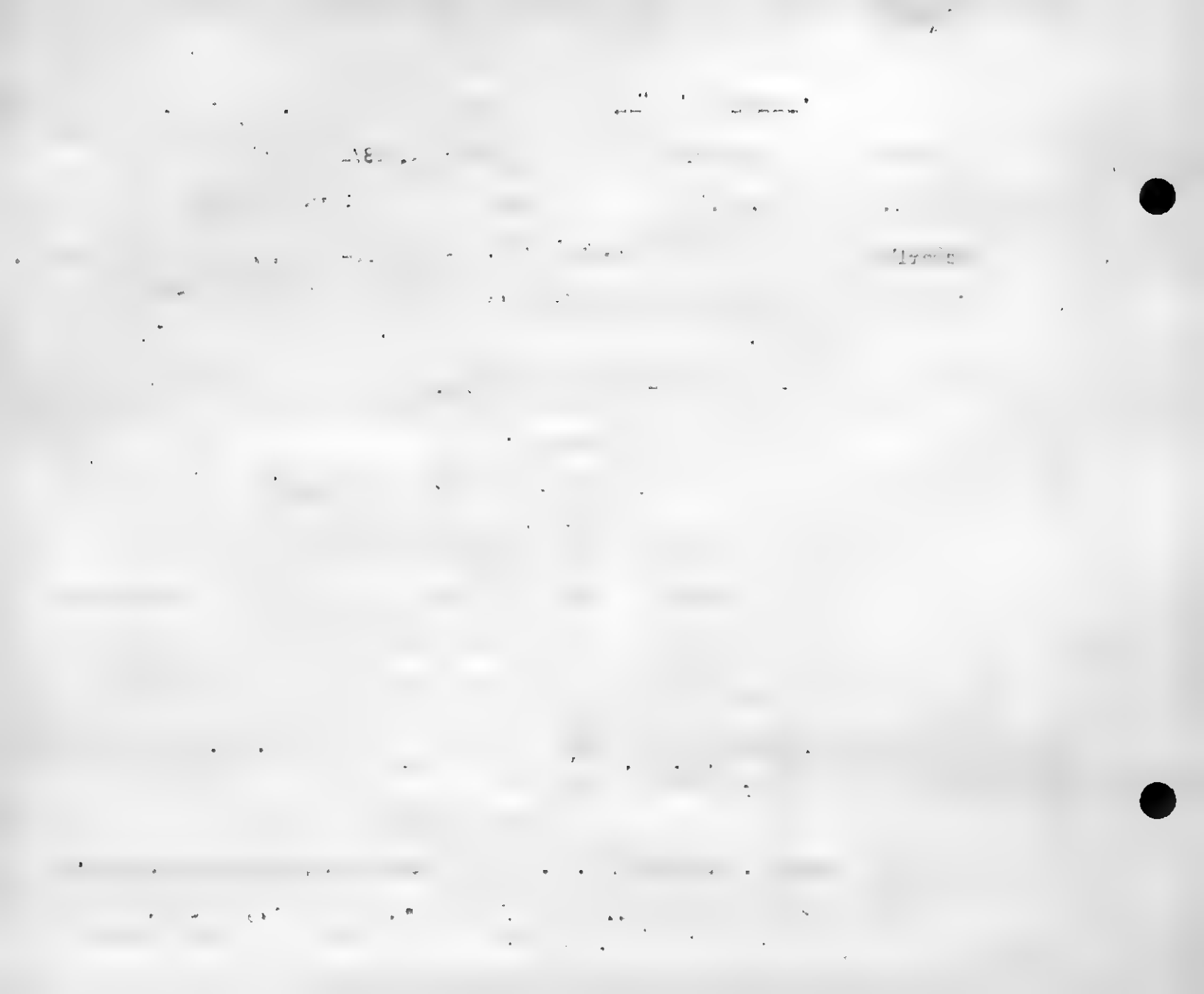
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01377

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01372

1. DECEASED NAME (Type or print) First <u>L. Maude</u> Middle <u>Maude</u> Last <u>Berry</u>			2a. DATE OF DEATH Jan. <u>31</u> , Day <u>1968</u> Year			2b. HOUR <u>7:40AM</u>			
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>July 31, 1872</u>		6. AGE (In years lost birthday) <u>95</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Penna.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince Georges</u> Md			
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince Geo. Gen'l Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Ret. - Comm. Dep.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Prince Georges</u>		13c. CITY OR TOWN <u>Brentwood</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>4303 37th Street</u>	
14. FATHER'S NAME First <u>Andrew D. Wilson</u> Middle Last			15. MOTHER'S MAIDEN NAME First <u>Margaret C. Bertholf</u> Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>217-52-5415</u>		17. INFORMANT Address <u>Mrs. Amy M. Ryan (above address)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Venous thrombosis</u> 45117 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral and peripheral vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>5-5-68</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <u>(did not)</u> attended the deceased from <u>1-30</u> , 19 <u>68</u> , to <u>Jan. 31</u> , 19 <u>68</u> , that (I) <u>(was)</u> lost saw the deceased alive on <u>Jan. 31</u> , 19 <u>68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(was)</u> (did) <u>(not)</u> view the body after death.									
22b. SIGNATURE <u>Ronald S. Fleischer</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1-31-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Ronald S. Fleischer, M. D.</u>				22e. ADDRESS <u>7411 Riggs Road, Hyattsville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Type) <u>Burial</u>		23b. DATE <u>2/5/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>W. Laurel Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Phila., Penna.</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>111 Rainier Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 5 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

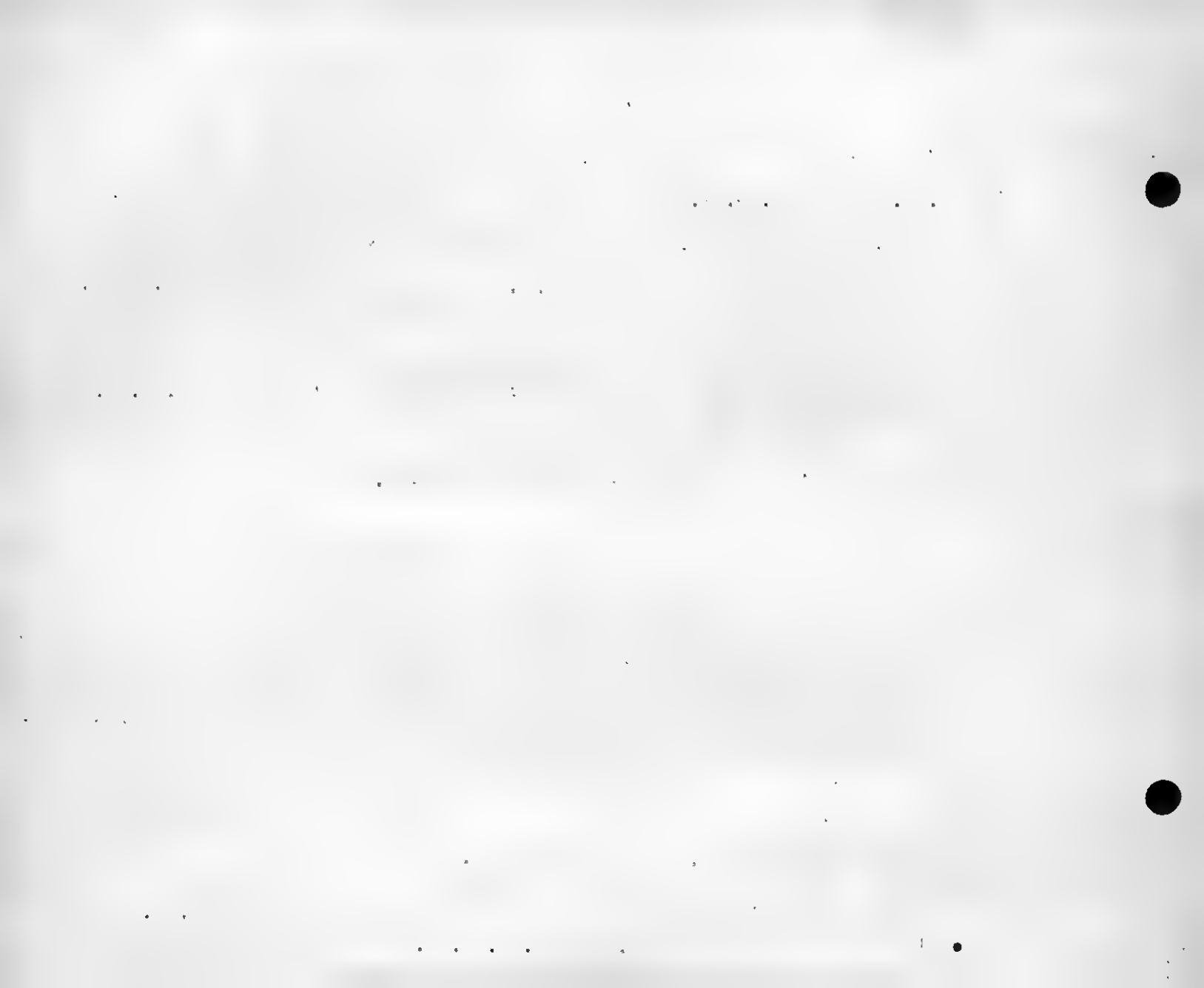
11378

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01373

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Tony		A.		Blakeney				Month 1 Day 13 Year 1968		2:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
male	Negro	11-23-114	23 YRS	MONTHS DAYS		HOURS MIN.		Month 1 Day 13 Year 1968		2:30 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
G. C.		U. S. A.				Prince George's Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Landover			Rte. 50 near Kenilworth			Truck driver					
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
-			-			D.C.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.					
Frank Blakeney			Gallay			Dunlap					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
						Jessie Blakeney 256 Warren, St. N. E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Laceration of brain</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Multiple skull fractures</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
21a. DATE OF OPERATION											
21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			2:15 AM 1-13-68			driver of car which struck bridge abutment					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			County State		
			Route 50 near Kenilworth Avenue Landover			P.G.			Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			1-13-68					
John Kehoe M.D., Riverdale, Md.			ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal			1/15/68						Charlotte, N. C.		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Love's Funeral Home			1425 Md. Ave, N. E. D.			DATE JAN 18 1968			Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH Day Year		2b HOUR	
John Michael Bolen						1-28-68		19 3:15am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	
Male	White	10-15-1951	16 YRS					1 28 68 19 3:15am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD		U.S.A.				Prince George's Md.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.			Prince George Colmar Manor					4307 Newton Street	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
CLAUDUS J. BOLEN			TESSIE E. KOUTSOS						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
NO			NONE			CLAUDUS J. BOLEN (SAME AS 13E)			
18. CAUSE OF DEATH (Enter on any one cause per line for (a) (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u>									
816.1 DUE TO, OR AS A CONSEQUENCE OF <u>Fracture of skull</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			12:35am 1-6-1968		Passenger of car which struck a telephone pole				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
		Leland Rd., 2500 ft. west of Rt. 301, Hall, Maryland							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			1-29-68			
John Kehoe, M.D. Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
BURIAL		1-31-68		ARLINGTON NAT. CEMT.		ARLINGTON, VIRGINIA			
24 FUNERAL DIRECTOR			ADDRESS			25a REGD. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
W.W. CHAMBERS CO. RIVERDALE, MD						FEB 13 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP -

31380

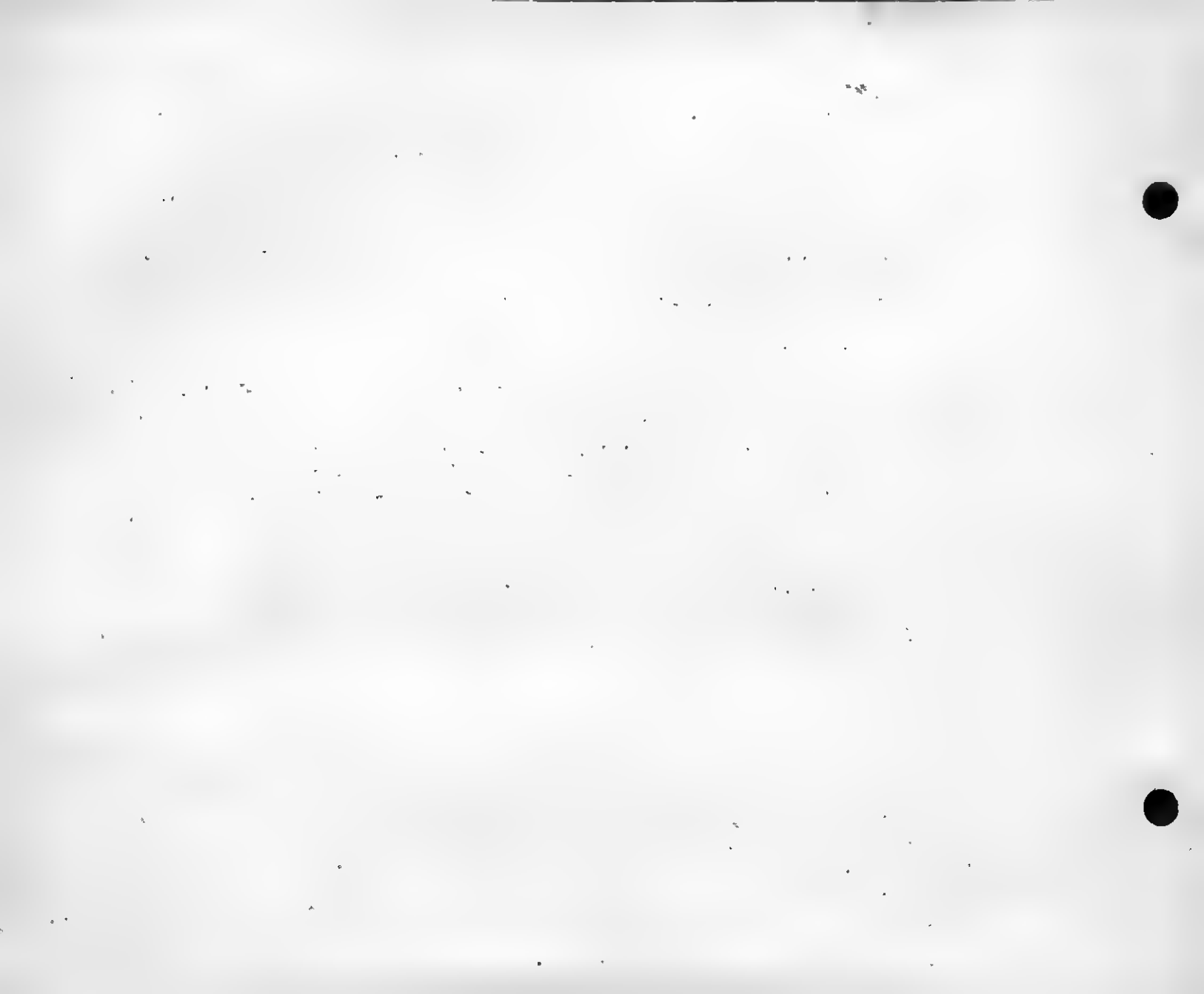
Items 3 & 16b Film 3396 1/14/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01374

1. DECEASED NAME (Type or print) Francis M. Bowie			2a. DATE OF DEATH Month Jan Day 3 Year 1968			2b. HOUR 5:30 M	
3. SEX Female Male		4. RACE white		5. DATE OF BIRTH Feb 22, 1910		6. AGE (In years last birthday) 57 YRS.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md	
10. CITY OR TOWN OF DEATH Hyattsville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5902 31st ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Food Manager		12b. KIND OF BUSINESS OR INDUSTRY U of Md	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Pro Geo		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5902 31st avenue							
14. FATHER'S NAME First Middle Last Frank Bowie			15. MOTHER'S MAIDEN NAME First Middle Last Lillian R. Murray				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 214 01 65708		17. INFORMANT Address Margaret R Bowie Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4107 (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary Infarction, Post-Carcinoma of Colon, Cecum							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 1-3 1968 , that (I) (we) last saw the deceased alive on 1-2 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald C. Edgren				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-3-68	
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN M.D.				22e. ADDRESS Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 6, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				25a. REC'D BY REGISTRAR JAN 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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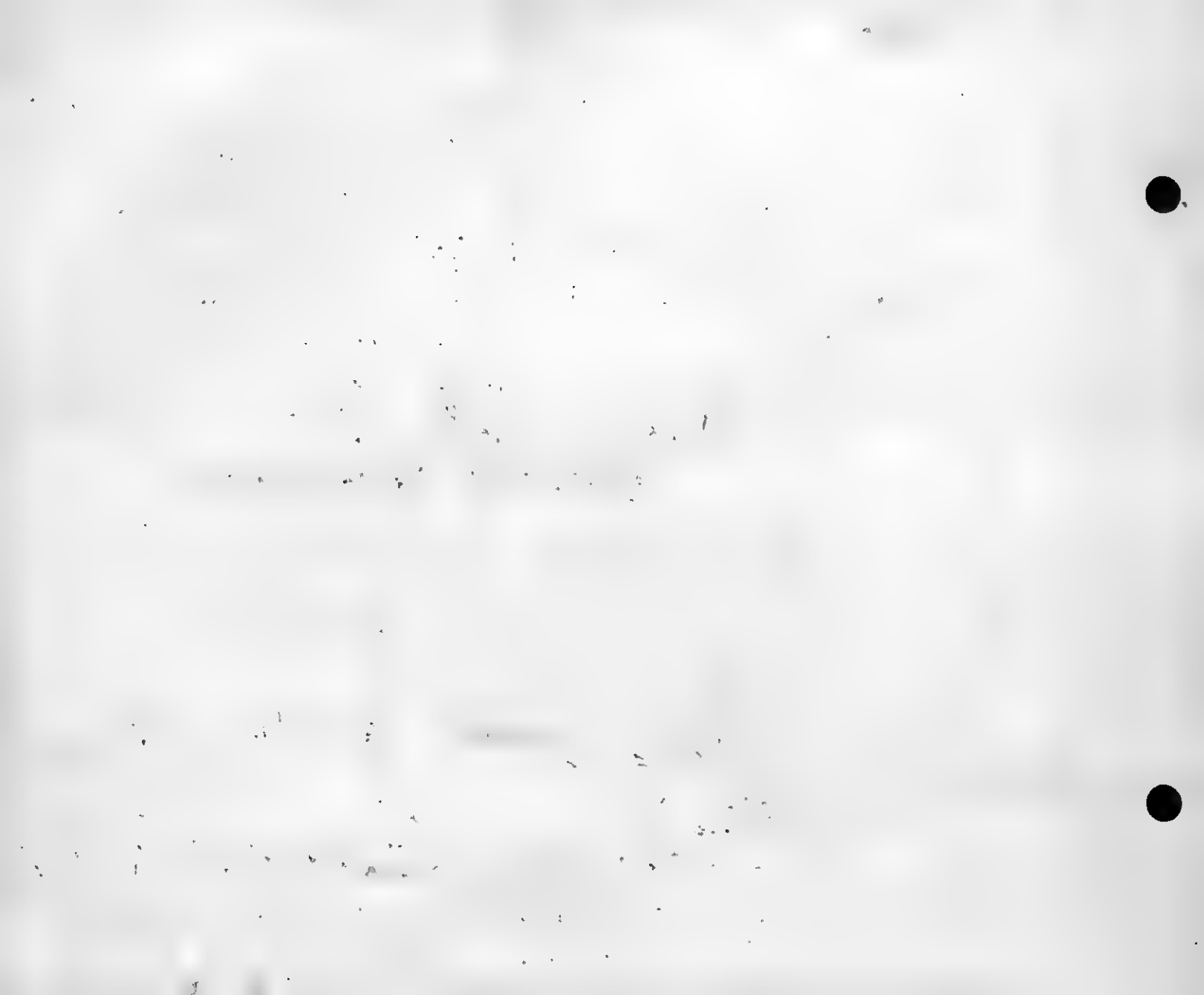
01381

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01375

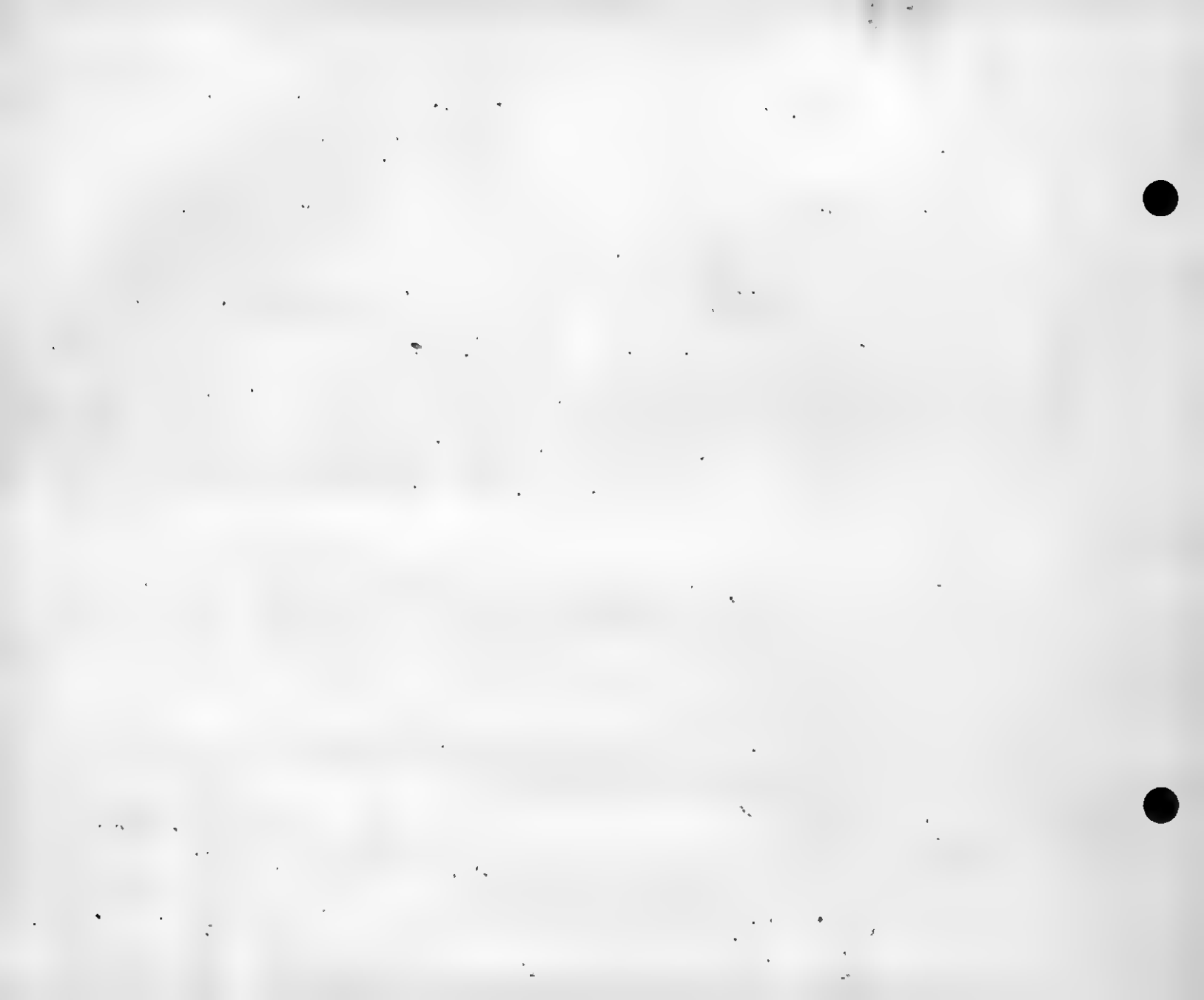
1. DECEASED-NAME (Type or print) <i>Ida A. Brickerd</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>21</i> Year <i>68</i>			2b. HOUR <i>10 P</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5/27/87</i>		6. AGE (In years lost birthday) <i>80</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Norway</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i> Md	
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Magnolia Gardens Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Riverdale</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>5514 Madison St.</i>		14. FATHER'S NAME First <i>Ole</i> Middle <i>Rasmussen</i> Last <i>Rasmussen</i>		15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Rasmussen</i> Last <i>Rasmussen</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>-</i>		17. INFORMANT <i>Magnolia Nursing Home, Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i> DUE TO, OR AS A CONSEQUENCE OF <i>abdominal carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>151</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 21</i> , 19 <i>68</i> , to <i>Jan 21</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Jan 21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W. Etienne</i>		DEGREE <i>W. Etienne</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-22-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>W. Etienne</i>		22e. ADDRESS <i>College Park Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 24, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Geo Md.</i>	
24. FUNERAL DIRECTOR <i>F Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01382										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01376														
Item 23c Film G397 1/24/68 kk										CERTIFICATE OF DEATH																								
1. DECEASED NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR																			
KATHERINE					L BROWN					JAN					Month 10 Day 68 Year					1:10 PM														
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					7. LINDER YEAR					8. UNDER 24 HRS									
F					CAU					APRIL 5, 1887					80 YRS.					MONTHS DAYS HOURS MIN														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.														
Frostburg					U.S.										Prince George																			
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY																			
Hattsville					Hattsville Nursing Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER														
Maryland					T. Adams Park										YES					711 Tuburn Ave														
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO					17. INFORMANT					Address									
Theodore					Wilson					Rebecca					No					578-66-8782					Mrs. Bernadette C. Jenkins					SCHELC				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																																		
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE																																		
DUE TO, OR AS A CONSEQUENCE OF																																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																																		
(b) ARTERIO SCLEROTIC HEART DISEASE																																		
DUE TO, OR AS A CONSEQUENCE OF																																		
(c)																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																		
SENILE DEMENTIA; Maturity Onset Diabetes Mellitus; Pyelonephritis																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
										YES <input type="checkbox"/> NO <input type="checkbox"/>																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
					HOUR A.M. Month Day Year P.M. 19																													
21d. INJURY OCCURRED					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION																								
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					(At home, farm, street, factory, office building, etc.)					Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from November, 1967, to 1/10, 1968, that (I) (we) last saw the deceased alive on JAN 9 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE					22c. DATE SIGNED																													
Ed Schele, M.D.					1/10/68																													
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																													
					MEDICAL ARTS BUILDING																													
					6480 NEW HAMPSHIRE AVE, TAKOMA PARK, MD.																													
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																			
Burial					Jan. 13, 1968					Frostburg Cemetery					Frostburg Md.																			
24. FUNERAL DIRECTOR (Name and address)															25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Takoma Funeral Home 154 Carroll St NE															DATE JAN 15 1968										William J. Yunge									

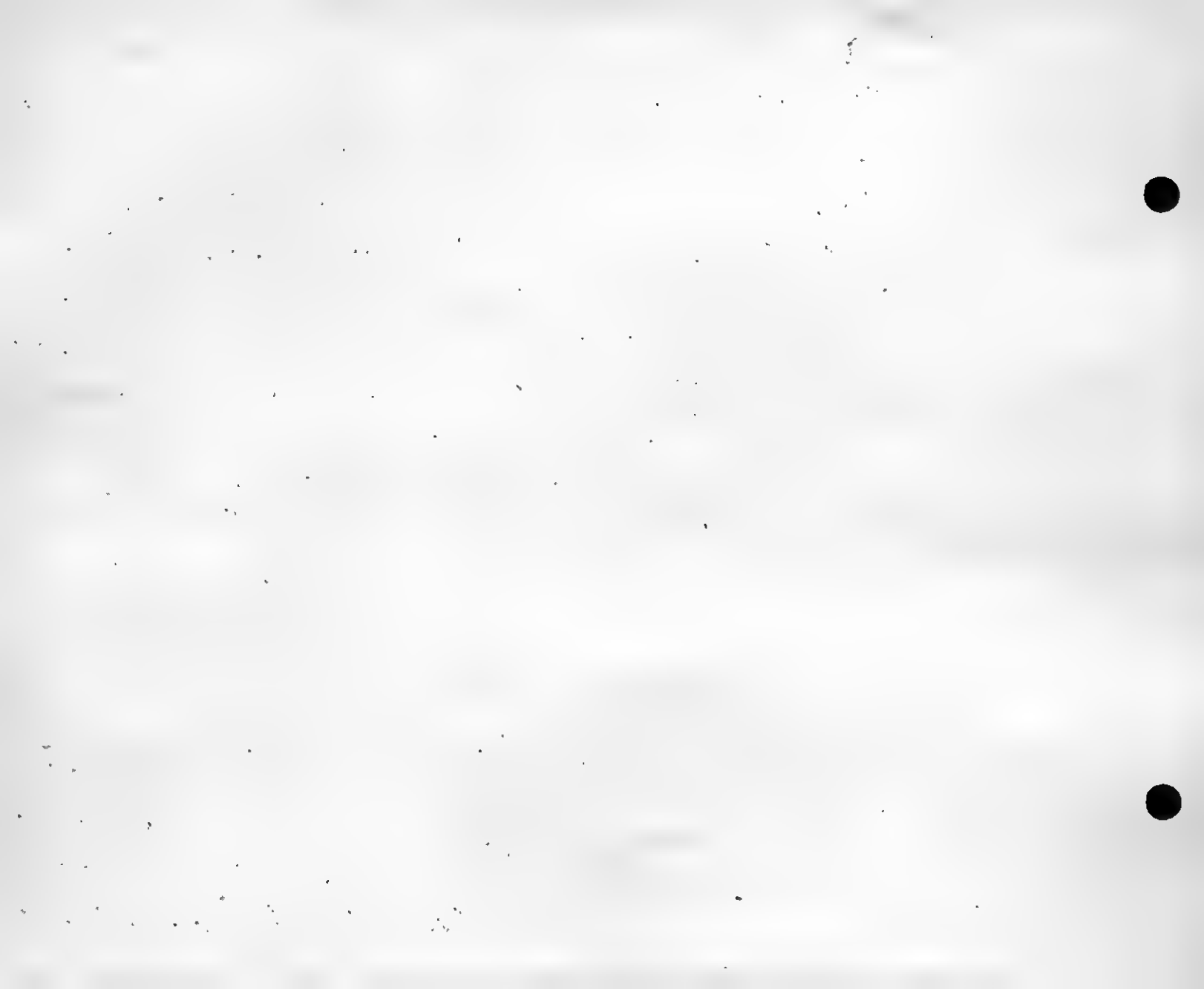


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VR AT 5 (4)
30M REV 1/68

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		Month	Day	Year	2b HOUR
Thomas		J.		Bruton	1		8	68	945	P M
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR		IF UNDER 2 HRS	
male	white		6-30-1879		87 YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Kentucky		U.S.A.				Prince George Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Hyattsville		Hyattsville Nursing Home				Public Accountant Auditor				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER				
md		Prince George LAUREL		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		102 Woodland Court				
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
Martin				Bruton	Anna				Horne	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address				
		112-24-89352		Mrs Thomas McBride		Daniel Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 410.7 CONGENITAL THROMBOSIS										15 min
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC HEART DISEASE										2 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 9/22, 1967, to 1/8, 1968, that (I) (we) last saw the deceased alive on 12/21, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Norman J. McCall									1/8/68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
NORMAN J. McCALL					3503 PENNY ST		RAINIER MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Burial		Jan. 11, 1968		Union Cemetery		Baltimore			Md.	
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William A. Marshall					Daniel Md		DATE		JAN 15 1968	
									Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten initials

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

013778

21284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) Minnie C Buckey			2a. DATE KNOWN OF DEATH: <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 1-16-68 191:30p M			2b. HOJR		
3 SEX Female	4. RACE White	5. DATE OF BIRTH 31 Dec. 1898	6. AGE (In years last birthday) 69 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 1 Day 16 Year 68 192:00pm M		
7a. BIRTHPLACE (State or foreign country) N C		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY store
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Md.			13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 3922 Oliver Street
14. FATHER'S NAME Alonzo Hill			15. MOTHER'S MAIDEN NAME Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Agnes Reymer		
						ADDRESS Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes over 5 yrs.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 yrs								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Kehoe</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 1-17-68		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE JAN 22 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

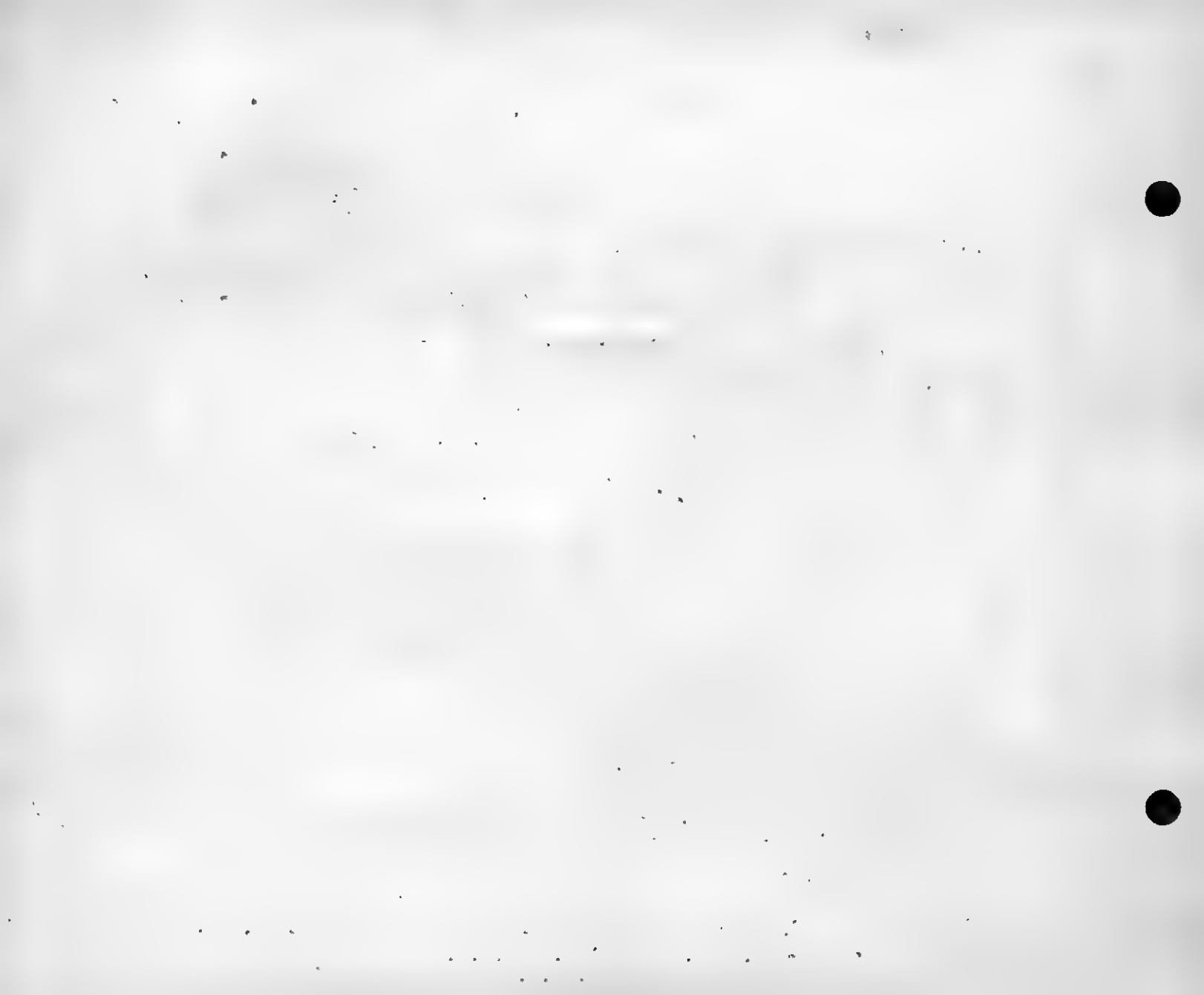
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

91385

01379

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Alice S. Burroughs</i>		2a. DATE OF DEATH Month <i>1</i> Day <i>24</i> Year <i>68</i>		2b. HOUR <i>1:51 A</i> M
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>10-15-14</i>	6 AGE (In years last birthday) <i>53</i> YRS.	IF UNDER 1 YEAR MONTHS <i>53</i> DAYS <i>53</i>
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George</i> Md.	
10. CITY OR TOWN OF DEATH <i>Clinton Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pine View Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Prince George</i>	13c. CITY OR TOWN <i>Suitland</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>7401 Penna. Ave. 7615 Atwood St. S.E.</i>
14. FATHER'S NAME First <i>JOHN</i> Middle <i>SEAMAN</i> Last <i>OLSEN</i>	15. MOTHER'S MAIDEN NAME First <i>-</i> Middle <i>-</i> Last <i>-</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>- - -</i>	17. INFORMANT Address <i>James V. Burroughs - See Item 13a-e</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiovascular Collapse</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 hr</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>11</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>1</i> Day <i>24</i> Year <i>68</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>-</i> City or Town <i>-</i> County <i>-</i> State <i>-</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>7-27</i> , 19 <i>67</i> , to <i>1-24</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-24</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Alfred K. Laper MD</i>	22c. DATE SIGNED <i>1-24-68</i>	22d. PHYSICIAN'S NAME (Type) <i>ALFRED K. LAPER, MD</i>		
22e. ADDRESS <i>CLINTON, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-27-1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Suitland, Md.</i> (County) <i>-</i> (State) <i>-</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</i>	25a. REC'D BY REGISTRAR <i>JAN 31 1968</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>		



FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH										01380							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01380							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First Tracy			Middle Marie			Last Carroll			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-4-68		2b. HOUR 9:00a M			
3 SEX Female		4. RACE Negro		5. DATE OF BIRTH 11-3-1967		6. AGE (In years last birthday) YRS 2		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD 1 Month 4 Day 68 19 1		2d. HOUR 4:45p M			
7a. BIRTHPLACE (State or foreign country) Md			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's			Md					
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Prince George's Gen. Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None				12b. KIND OF BUSINESS OR INDUSTRY None					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Prince George's				13c. CITY OR TOWN Upper Marlboro				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 4403			
14. FATHER'S NAME First Middle Last			Lewis Carroll			15. MOTHER'S MAIDEN NAME First Middle Last			Anna Mac Mullins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO None			17. INFORMANT Lewis Carroll			ADDRESS Same as 2D					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SDII																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										(b)							
DUE TO, OR AS A CONSEQUENCE OF										(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										7952							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE John Kehoe				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 1-5-68					
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
								ADDRESS (Street, city, town or county)									
23a. BURIAL (CREMATION, REMOVAL) (Specify)				23b. DATE 1-8-68				23c. NAME OF CEMETERY OR CREMATORY Holy Family Cem.				23d. LOCATION (City or Town) Woodmont (County) Md					
24. FUNERAL DIRECTOR R.S. Washington & Sons				ADDRESS 4925 Deane Ave N.E.				25a. REC'D BY REG. STRAR DATE JAN 10 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

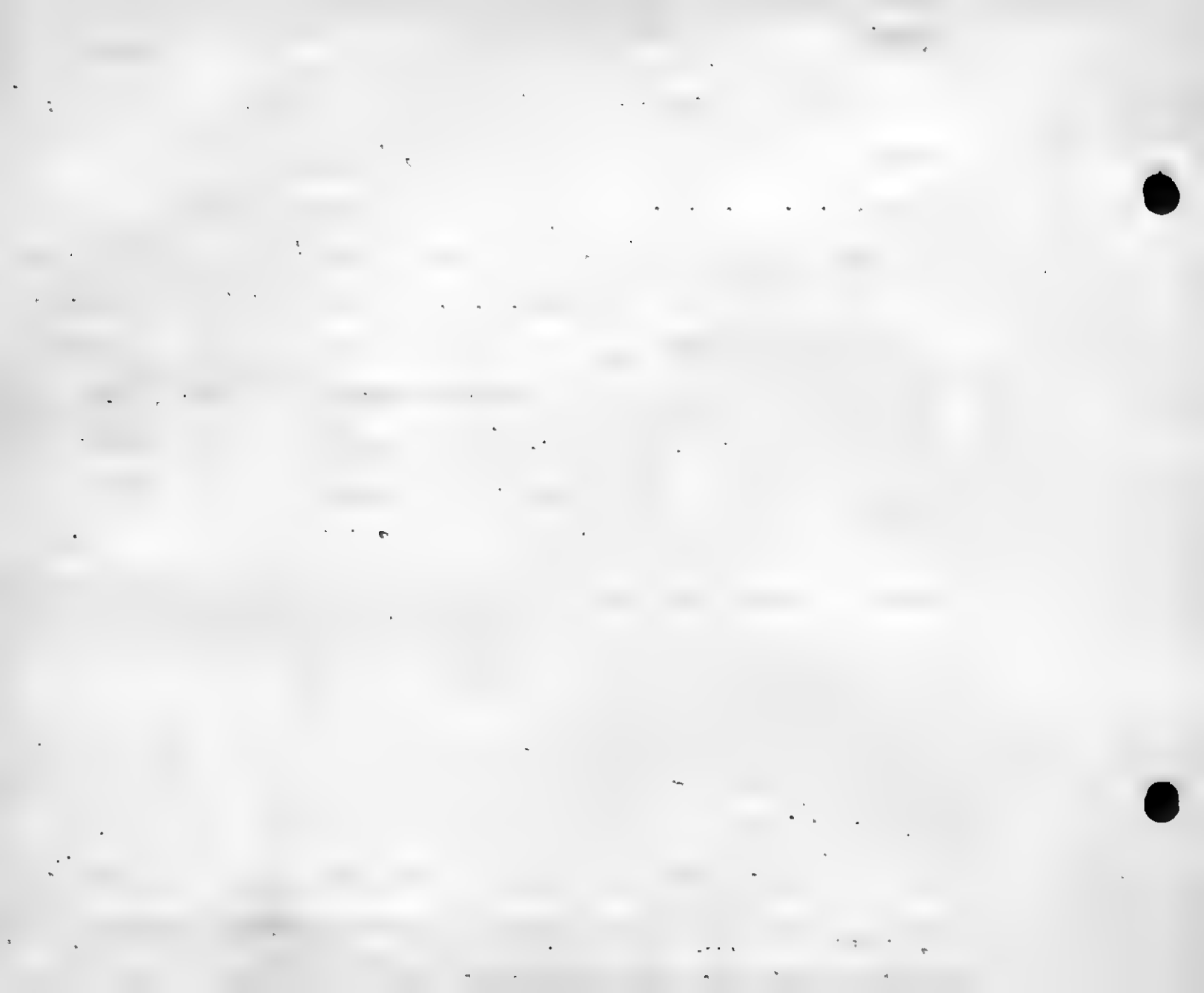
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01387

01381

1. DECEASED NAME (Type or print) MARGARET GENEVIEVE CARTER			2a. DATE OF DEATH Month January Day 9 Year 1968			2b. HOUR 5:30 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 7, 1881		6. AGE (In years last birthday) 86 years		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville, Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash. D. C.		13b. COUNTY 		13c. CITY OR TOWN Wash. D. C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 215 Emerson Street, N. W.	
14. FATHER'S NAME First Middle Last Bartholomew Callon			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Crawford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. Yes		17. INFORMANT Margaret Fellows		17b. ADDRESS 9510 Ritten Road Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, general								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours 2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Aug 8, 1967 to Jan 9, 1968 , that (I) was last saw the deceased alive on Jan 8, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.									
22b. SIGNATURE John D. Brennan		22c. PHYSICIAN'S NAME (Type) John D. Brennan		22d. ADDRESS 4401 East West Highway, Bethesda, Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED Jan 9, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE January 12		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington Virginia			
24a. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		24b. ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR JAN 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

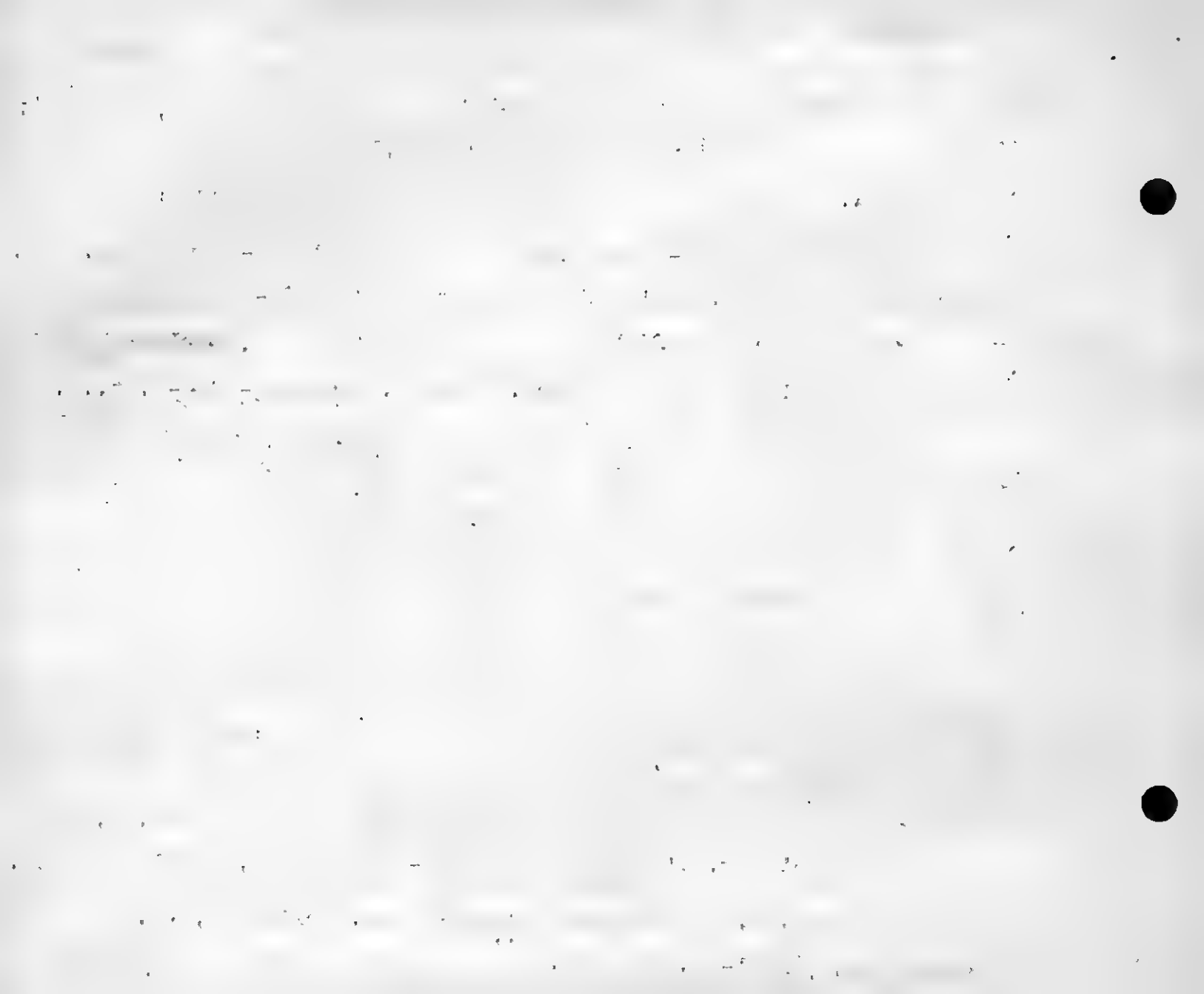
01382

1 DECEASED-NAME (Type or print) Cecil Ray Chapman			2a. DATE OF DEATH Jan 6th, 1968			2b. HOUR 12:30 P.M.				
3 SEX Male		4. RACE White		5 DATE OF BIRTH March 28, 1920		6. AGE (In years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) West Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md				
10. CITY OR TOWN OF DEATH Camp Springs			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5439- Linda Lane			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machinist - Naval Res. Lab.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland			13b. CITY Pr. Geo'S Camp Springs			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET AND NUMBER 5439- Linda Lane	
14. FATHER'S NAME First Middle Last Otis G. Chapman			15. MOTHER'S MAIDEN NAME First Middle Last Elsie M. Chapman Miller			Mother				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO WW11			17. INFORMANT Mrs. Elsie M. Chapman - 5204-T. St. SE.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 397.7 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>14x</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from <u>Jan 6, 1968</u> to <u>Jan 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 6, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Timothy F. O'Donovan</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan. 6, 1968				
22d PHYSICIAN'S NAME (Type) Timothy F. O'Donovan				22e. ADDRESS 4400- Stamp Road, Temple Hill Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 10, 68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Va.				
24 FUNERAL DIRECTOR <u>Simmons Bros.</u>				ADDRESS Wash., DC		25a. REC'D BY REGISTRAR DATE JAN 9 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
25c. ADDRESS 1661-Gd. Hope Rd. SE										

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Correctly filled out and submitted to the State Dept. of Health



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Frank			Stuart			Chappell			January 29 1968 8:45 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Nov. 14 1886		81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Bradford, Pa.		U.S.				Prince George Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hyattsville			Hyattsville Nursing Home			Certified Public Accountant			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. dence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Hyattsville, Md.			Prince George			Hyattsville		6905-20th Ave	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edwin B. Chappell			Laura Elizabeth Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
						Nursing Home Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Atherosclerosis									2 yrs
4121 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus Emphysema Bronchopneumonia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct 7, 1967, to Jan 29, 1968, that (I) (we) last saw the deceased alive on Jan 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Theodore J. ABERNETHY M.D.								1-29-68	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
THEODORE J. ABERNETHY			916-19th St NW Washington, D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
1/31/68			1/31/68		Ft. Lincoln Cemetery		Prince Georges County, Md		
24. FUNERAL DIRECTOR The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington, L.C.						25a. REC'D BY REGISTRAR DATE FEB 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

If known, please state primary site.

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Items 18c, 19, 20a Film 397
2-1-68
Item 6-1111 G397 2/6/68 kk

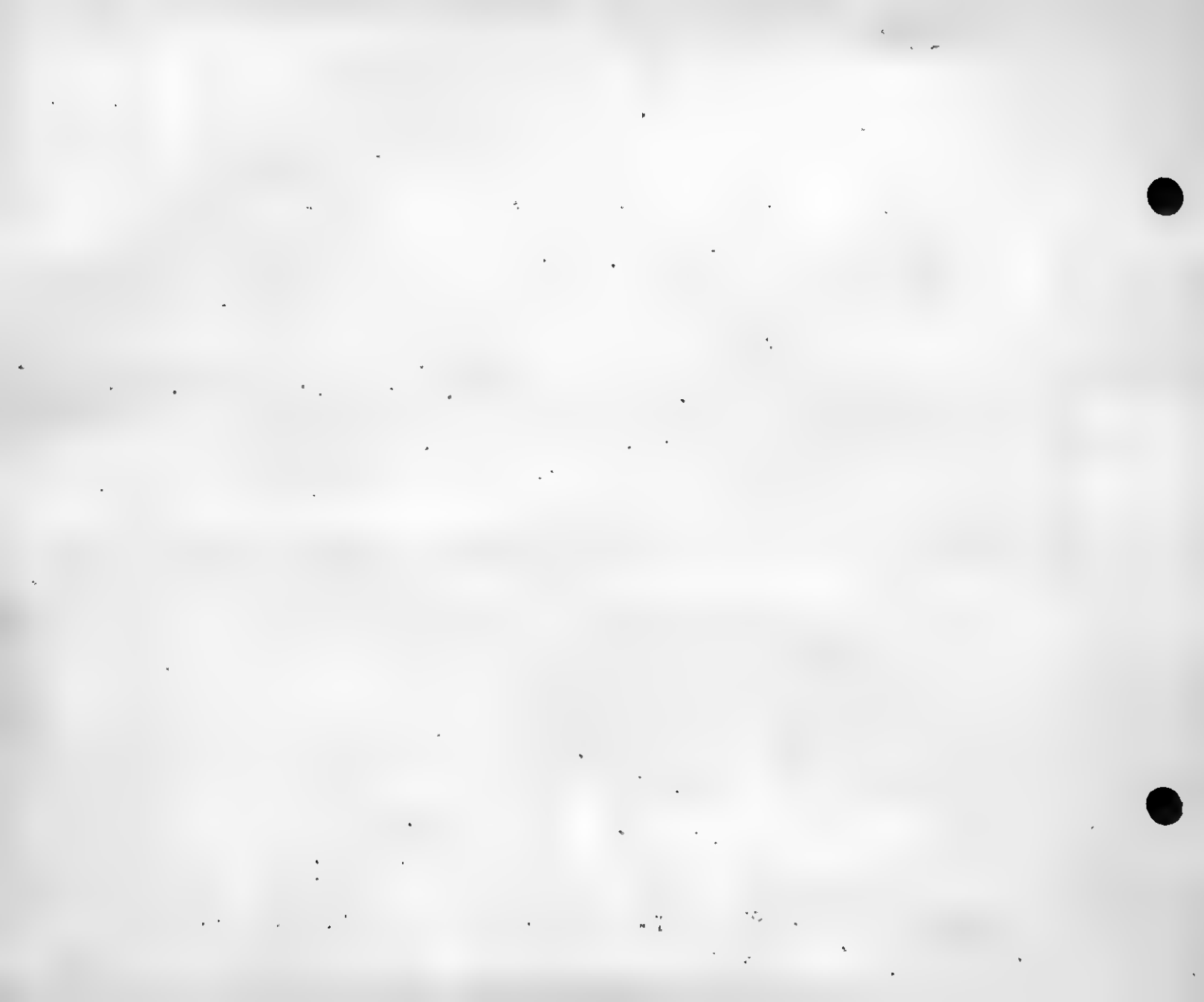
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01384

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) BRUCE			First N.			Middle N.			Last CHASE			2a. DATE OF DEATH Month 1 Day 27 Year 1968			2b. HOUR 10 M		
3 SEX F			4. RACE W			5. DATE OF BIRTH 10-12-86			6. AGE (In years last birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS. HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) Illinois			7b. CITIZEN OF WHAT COUNTRY? United States America			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTRY OF DEATH Rome, Georgia			12b. KIND OF BUSINESS OR INDUSTRY					
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Gardens			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Virginia			13b. COUNTY Alexandria			13c. CITY OR TOWN Alexandria			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4009 Laurel Rd.					
14. FATHER'S NAME William E. Wiper			First William E. Middle Wiper Last Wiper			15. MOTHER'S MAIDEN NAME Littie Bruce			First Littie Middle Bruce Last Bruce								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If you give war or dates of service)			16b. SOCIAL SECURITY NO 226-66-6253			17. INFORMANT Martin N. Chase			Address 4009 Laurel Rd., Alexandria, Va.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ca. disease rel. col. of 174x DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) CA of Rt Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH if 2 yrs. 5+ yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION 5/2/62			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Breast Rt			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 4/1/66 19 66 to 1/27/68 19 68 , that (I) (we) last saw the deceased alive on 1/27/68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Alfred R. Felt...			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/29/68		
22d. PHYSICIAN'S NAME (Type) Alfred R. Felt...			22e. ADDRESS Chick Town, Va.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/2/1968			23c. NAME OF CEMETERY OR CREMATORY Toulon Cemetery			23d. LOCATION (City or Town) (County) (State) Toulon, Illinois								
24. FUNERAL DIRECTOR James W. O'Driscoll			ADDRESS Alexandria, Va.			25a. REC'D BY REGISTRAR DATE FEB 2 1968			25b. REGISTRAR'S SIGNATURE Richard J. Judge								

VR A15 (4)
304 REV. 1/68



CERTIFICATE OF DEATH

01385

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE md. b. COUNTY P-G-C	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b LA PLATA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CLINTON COMMUNITY HOSPITAL		d. STREET ADDRESS WOODYARD RD. CLINTON	
3. NAME OF DECEASED (Type or print) BERNARD CHESLEY		4. DATE OF DEATH Month Jan Day 14 Year 1968	
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888 2/13/89
9. AGE (In years (m)day) 78 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	
10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (County & State, or foreign country) CHARLES County U.S.	
13. FATHER'S NAME Frank Chesley		14. MOTHER'S MAIDEN NAME Julia Ann Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-38-4945	
17. INFORMANT Eleanor Chesley, La Plata, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 4 in DUE TO DEEP VEIN THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4381 DUE TO (b) CHRONIC CONG. HEART FAILURE DUE TO (c) > 1 YR.		INTERVAL BETWEEN ONSET AND DEATH 3 YRS. UNK.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FLU, PNEUMONIA, HYPERTENSIVE ARTS. CV DISK			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF F THER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 1:15 o.m. 1-14 1968	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 14, 1968 to DEATH , that (I) (we) last saw the deceased alive on JAN 14 1968 , and that death occurred at 1 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert W. Merkle M.D.		22b. DATE SIGNED JAN 14/68	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT W. MERKLE M.D.		22d. ADDRESS BRANDYWINE, M.D.	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-17-68	23c. NAME OF CEMETERY OR CREMATORY Holy Ghost	23d. LOCATION (City or Town) (County) (State) Issue Ches med
24. FUNERAL DIRECTOR Richard Turner/Hornum & Opalata		25a. REC'D BY REGISTRAR JAN 19 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01392

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01386

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
Phillip				Chipman	Jan. 3, 1968		7:20 PM	
3. SEX	Male	4 RACE	Caucasian		5. DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
					Nov 1, 1880	87 YRS.		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Washington D C	U S A				Prince Georges Md			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly	Prince Georges Gen'l Hosp.		Electrician		Electric co			
13a U.S. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
Maryland	Prince Georges		Brentwood		3818-38th St.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
George B				Chipman	Margaret			Bowie
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) no		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
		579 34 0553		Edna Chipman		Brentwood, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>								
41-27 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary arteriosclerosis</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
451								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that I (was hospital) attended the deceased from <u>July 15, 1964</u> , to <u>Jan 3, 1968</u> , that I (was) saw the deceased alive on <u>Jan 3, 1968</u> , and that in my (was) opinion death occurred on the date and hour and from the causes stated above. I (was) (did) (did not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED		
<u>Don B. Cameron</u>						<u>Jan 4, 1968</u>		
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS						
Don B. Cameron, M. D.		3503 Perry Street, Mt. Rainier, Maryland						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Jan 6, 1968		Rock Creek Cemetery		Washington D. C.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
F. Gasch's Sons				Hyattsville, Md..		JAN 8 1968		<u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01393

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01387

1. DECEASED-NAME (Type or print) Gertrude ^{First} C. ^{Middle} Clifford ^{Last}			2a. DATE OF DEATH Month Jan. Day 6th. Year 1968			2b. HOUR 3.10	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 11th, 17		6. AGE (In years last birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) N. Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Oxon Hill		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5106- Shelby Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Pr. Geo's		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5106- Shelby Drive	
14. FATHER'S NAME First John Middle Connors Last Connors			15. MOTHER'S MAIDEN NAME First Mary Middle Hagan Last Hagan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address Edward C. Clifford (Husband) Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 5/1/68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS							PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1966 , to 1/6, 1968 , that (I) (we) last saw the deceased alive on DEC. 1, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Bruno Kolega</i>		22c. DATE SIGNED 1/6/68		22d. PHYSICIAN'S NAME (Type) BRUNO KOLEGA			
22e. ADDRESS 4400 STAMP RD TEMPLE HILL - MD		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City or Town) (County) (State) Clinton, Maryland	
24. FUNERAL DIRECTOR <i>Simmons Bros</i>		ADDRESS Wash., DC		25a. REC'D BY REGISTRAR JAN 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. ADDRESS 1661-Gd. Hope Rd. SE.							

II.

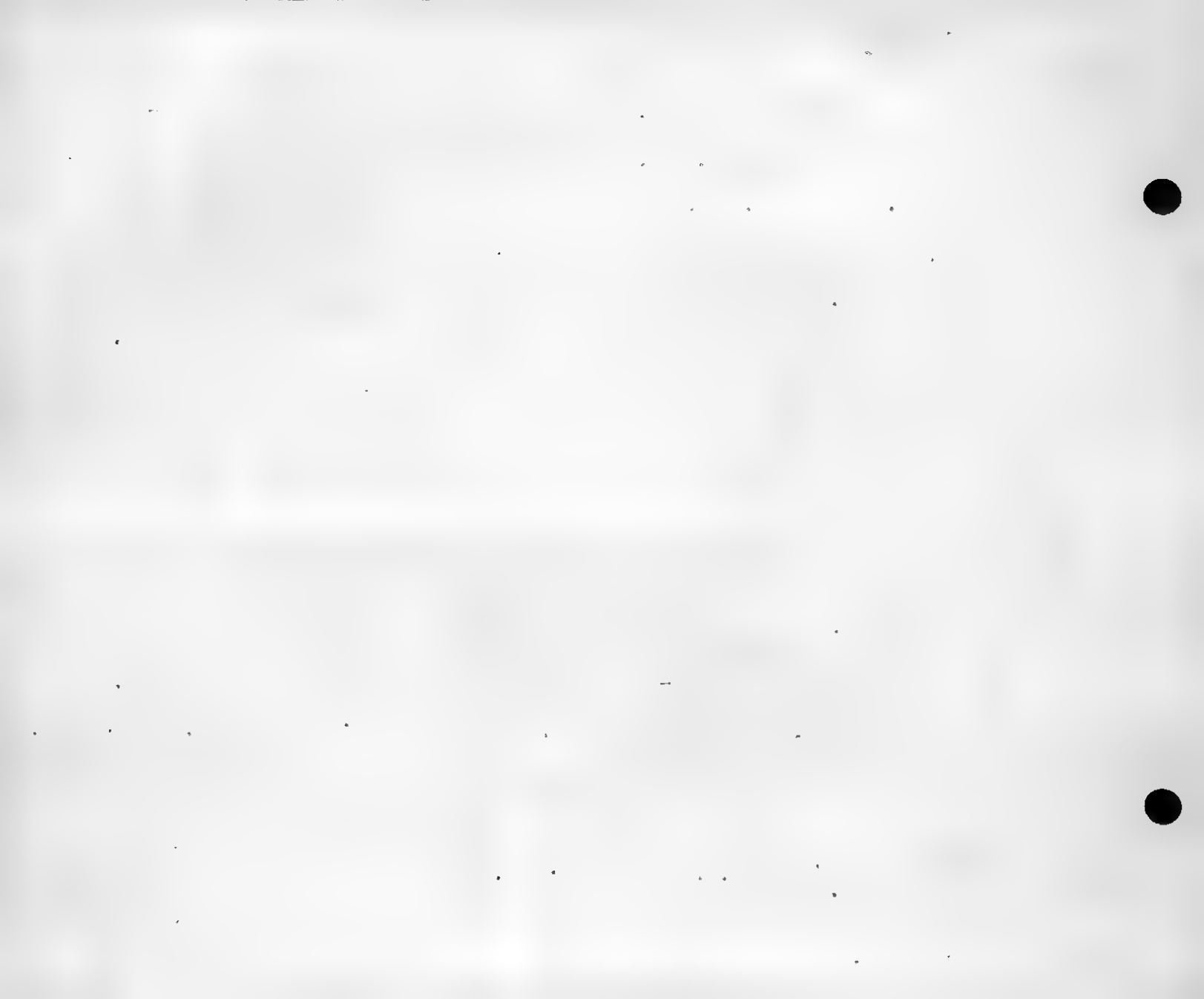
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or Print) <u>Claire Cole</u>										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>1</u> Day <u>14</u> Year <u>68</u>		2b HOUR <u>12:50p</u>					
3 SEX <u>Female</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>23 Aug. 1936</u>		6 AGE (In years last birthday) <u>31</u> YRS		IF UNDER 1 YEAR MONTHS <u>1</u> DAYS <u>14</u>		IF UNDER 24 HRS HOURS <u>12</u> MIN <u>50</u>		2c DATE PRONOUNCED DEAD Month <u>1</u> Day <u>14</u> Year <u>68</u>		2d HOUR <u>12:50p</u>			
7a BIRTHPLACE (State or foreign country) <u>Mass.</u>				7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <u>Prince George's</u>					
10 CITY OR TOWN OF DEATH <u>Cheverly</u>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George Hospital</u>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>				12b KIND OF BUSINESS OR INDUSTRY <u>-</u>					
13a USUAL RESIDENCE (Where deceased lived if institution admission) STATE <u>Md.</u>				13b COUNTY <u>Prince George</u>				13c CITY OR TOWN <u>Greenbelt</u>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>8577 Brae Brook Apartments</u>			
14 FATHER'S NAME First <u>Roger</u> Middle <u>Keliher</u> Last <u>McCarthy</u>						15 MOTHER'S MAIDEN NAME First <u>Julia</u> Middle <u>McCarthy</u> Last <u>McCarthy</u>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>No</u>				16b SOCIAL SECURITY NO <u>-</u>				17 INFORMANT <u>Hospital Records</u>				ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>And multiple abdominal injuries</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION <u>1-13-68</u>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Intra- abdominal bleeding</u>								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year <u>6:05pm 1-12- 1968</u>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8) <u>Struck by car while crossing street.</u>									
21d INJURY OCCURRED <input type="checkbox"/> WHITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>St. Rt. 193 Glendale Rd.</u>				21f LOCATION Street or RFD No <u>1500 ft. west of Cipriano Rd., Prince Geo. C.</u>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>John Kehoe</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>				ADDRESS (Street, city, town, or county) <u>Riverdale, Md.</u>				22b DATE SIGNED <u>1-14-68</u>									
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE <u>1/19/68</u>				23c NAME OF CEMETERY OR CREMATORY <u>Quincy City Cem.</u>				23d LOCATION (City or Town) (County) (State) <u>Quincy, Mass.</u>					
24 FUNERAL DIRECTOR <u>Home Ind. Valley's Funeral Home</u>				ADDRESS <u>1 Maryland</u>				25a. REC'D BY REGISTRAR <u>JAN 18 1968</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

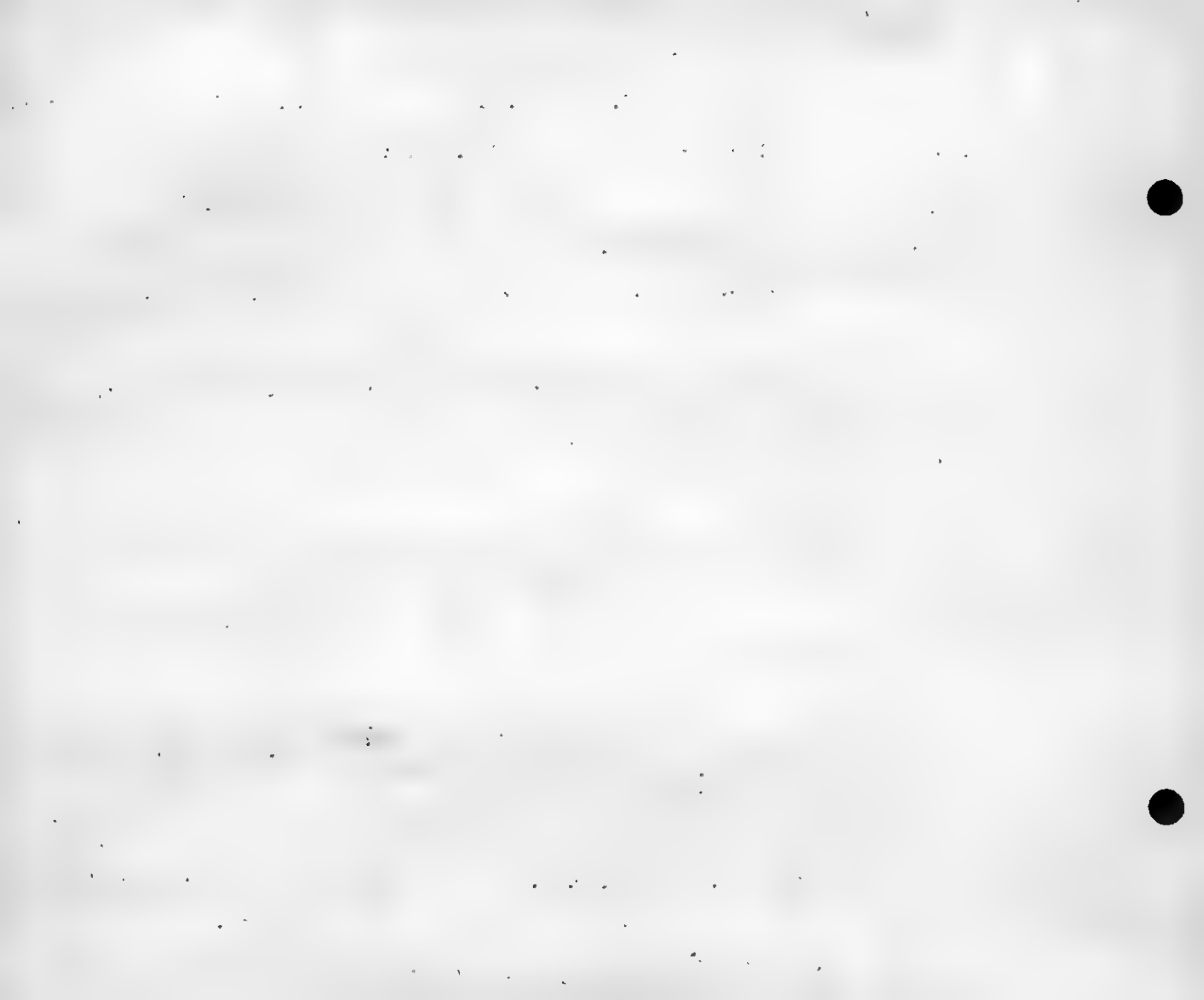
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. LENGTH OF STAY IN 1b 8 YRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MAGNOLIA GARDEN NURSING HOME LONHAM MD.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE, MD. d. STREET ADDRESS 812 SHERIDAN ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle COLE Last COLE		4. DATE OF DEATH Month JAN Day 3 Year 1968	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 22 1881
9. AGE (In years last birthday) 86 yrs.		10. FINDER 1 YEAR Months 86	10. FINDER 24 HRS. Hours 86 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) MASS.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PATRICK DEVINE COUGHLIN	
14. MOTHER'S MAIDEN NAME MARGARET DEVINE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 022 16 3635		17. INFORMANT Address MRS. C. CURLEY 812 SHERIDAN ST HYATTSVILLE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 3 months			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from DEC 15, 1967 to JAN 3, 1968 , that (I) (we) last saw the deceased alive on JAN 3, 1968 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Leon R. Levitsky		22b. DATE SIGNED 1-4-68	
22c. PHYSICIAN'S NAME (Type) LEON R. LEVITSKY		22d. ADDRESS 3408 R. I. AVE. MT. RAINIER, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JAN. 6 1968	23c. NAME OF CEMETERY OR CREMATORY EMMACULATE CONCEPTION CEM.	23d. LOCATION (City, town or county) (State) LAWRENCE MASS.
24. FUNERAL DIRECTOR W.W. CHAMBERS Co		25a. REC'D BY REGISTRAR JAN 9 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS RIVERDALE, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 1-5 (4)
30A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Howard E. Contee						Jan. Month 8, Day 68 Year		7:55AM	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		Negroid		Aug. 27, 1902		65 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Prince Georges		Md	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo. Gen'l Hospital							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Prince Georges		Upper Marlboro		9136 Dorsey Road			
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
unknown			unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
					Grace M. Contee-wife-9136 Darcy Road				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic pancreatitis</u> <u>5/11/68</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>5/11/68</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1/5</u> , 19 <u>68</u> , to <u>Jan. 8</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Jan. 8</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.									
22b. SIGNATURE <u>Frederick H. Wilhelm</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/8/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Frederick H. Wilhelm, M. D.</u>					22e. ADDRESS <u>6319 Landover Rd, Cheverly, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/12/68		Harmony Memorial Park		Maryland			
24. FUNERAL DIRECTOR <u>John T. Stewart</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>William D. Duggan</u>		
Stewart Funeral Home-4001 Benning Rd.,									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01397

01391

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN TB 36 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 605 Rittenhouse St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grover Middle C. Last Cooksey				4. DATE OF DEATH Month January Day 18 Year 19 68			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1885		9. AGE (n years lost birthday) yrs 82	10. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auto MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AUTO		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Somerset Cooksey				14. MOTHER'S MAIDEN NAME Elizabeth Swann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-48-0305		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost coronary artery DUE TO (b) Coronary artery disease with occlusion of right (c) years							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary infarction; arterioneurophrosclerosis; old healed myocardial infarction; pulmonary tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 67 , to 1/18 , 19 68 , that (s) (we) last saw the deceased alive on 1/18 , 19 68 , and that death occurred at 7:55PM , from causes and on the date stated above							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/18/1968	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-22-68		23c. NAME OF CEMETERY OR CREMATORY MT. REST		23d. LOCATION (City or Town) (County) (State) LA PLATA CHARLES MD	
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.				25a. REC'D BY REGISTRAR JAN 23 1968		25b. REGISTRAR'S SIGNATURE Charles M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01298

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01392

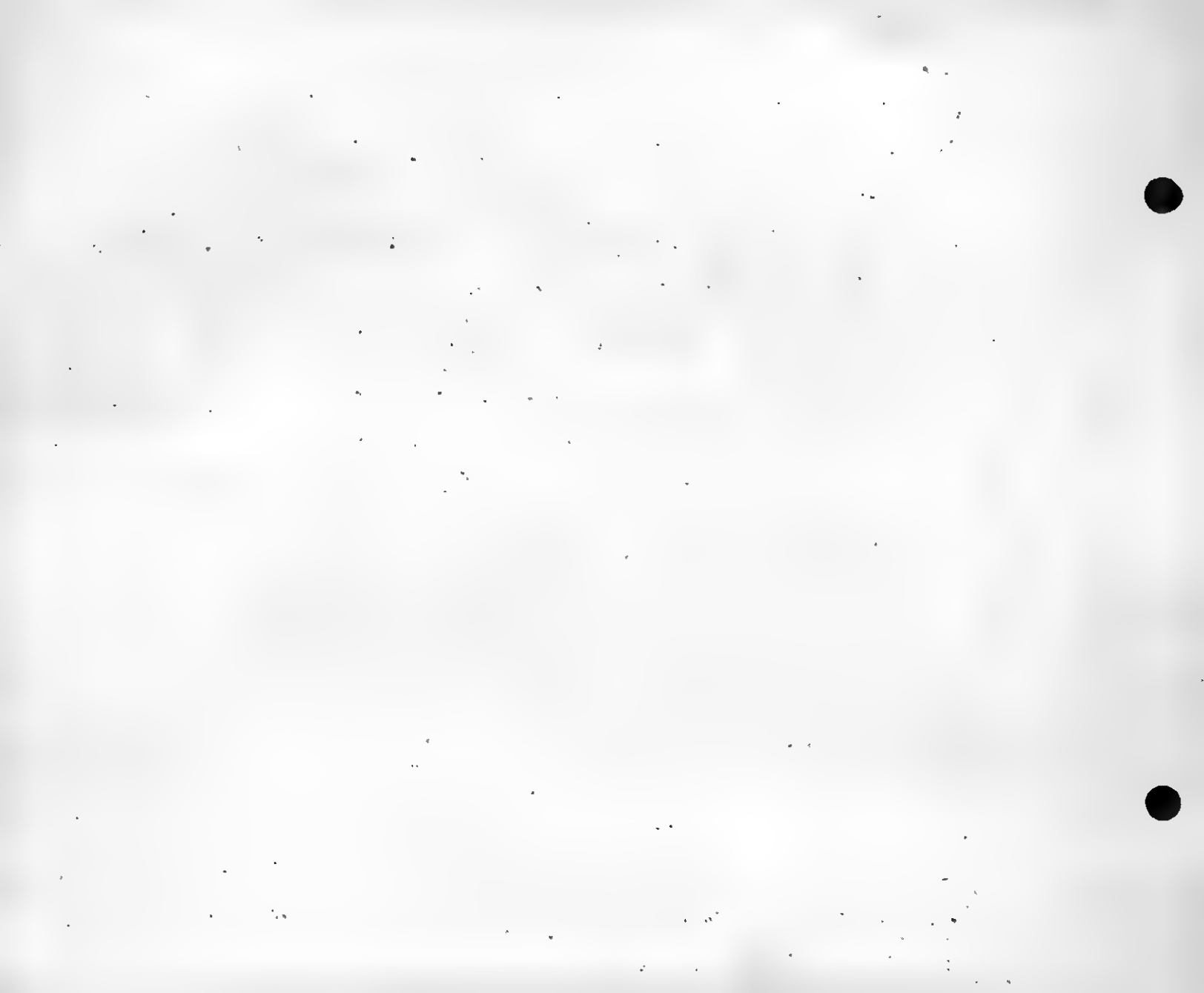
1. DECEASED-NAME (Type or print) ELIZABETH		First	Middle	Lost	2a. DATE OF DEATH 1 Month 14 Day 68 A.D.		2b. HOUR 10 40 P.M.	
3. SEX F	4. RACE N	5. DATE OF BIRTH 4-11-1865			6. AGE (in years last birthday) 102 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) V.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY		13c. CITY OR TOWN D.C.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4510 PORTER AVE. S.E.		
14. FATHER'S NAME UNKNOWN		First	Middle	Lost	15. MOTHER'S MAIDEN NAME UNKNOWN		First	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-56-1326	17. INFORMANT Wilmer R. Shaw		Address 4510 Porter Ave. S.E. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Senility								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10-30, 1967 , to 1-14, 1968 , that (I) (we) last saw the deceased alive on 1-14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Alfred R. Lapin M.D.					DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN					22e. ADDRESS CLINTON, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-18-68		23c. NAME OF CEMETERY OR CREMATORY HARMONY		23d. LOCATION (City or Town) (County) (State) LANDOVER, MD.		
24. FUNERAL DIRECTOR Kellins Funeral Home, Inc.		ADDRESS 4339 - Hunt Pl. N.E. Washington, D.C.		25a. REC'D BY REGISTRAR DATE JAN 18 1968		25b. REGISTRAR'S SIGNATURE Charles Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbal papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
01399												
1. DECEASED NAME (Type or print) ESTELLE First COOPER Last						2a. DATE OF DEATH 1 Month 24 Day 68 Year			2b. HOUR 10:00 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 15 - 1881		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) GA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges. Md.						
10. CITY OR TOWN OF DEATH SILVER SPRING, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1201 N. HAVENUE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CASHIER - GROCERY STORE			12b. KIND OF BUSINESS OR INDUSTRY MOORE STORES			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD.			13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9201 N. HAVENUE			
14. FATHER'S NAME Emmettine S. Brown First Baron Middle Elizabeth Last Torman				15. MOTHER'S MAIDEN NAME First Elizabeth Middle Torman Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Juanita Kent Address 1220 Broadway Dr. Prince Georges, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Acute Myocardial Infarction												
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No			City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-22, 1968 , to 1-24, 1968 , that (I) (we) last saw the deceased alive on 1-22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Morton Altschuler, M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 1-24-68						
22d. PHYSICIAN'S NAME (Type) Morton Altschuler M.D.						22e. ADDRESS 3205 New Hampshire Ave. S.W.						
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE Jan 29 - 1968		23c. NAME OF CEMETERY OR CREMATORY Magnolia		23d. LOCATION (City or Town) Augusta		(County)		(State) GA.	
24. FUNERAL DIRECTOR James D. Smith ADDRESS 254 Carroll St. N.W.						25a. REC'D BY REGISTRAR JAN 30 1968		25b. REGISTRAR'S SIGNATURE James D. Smith				

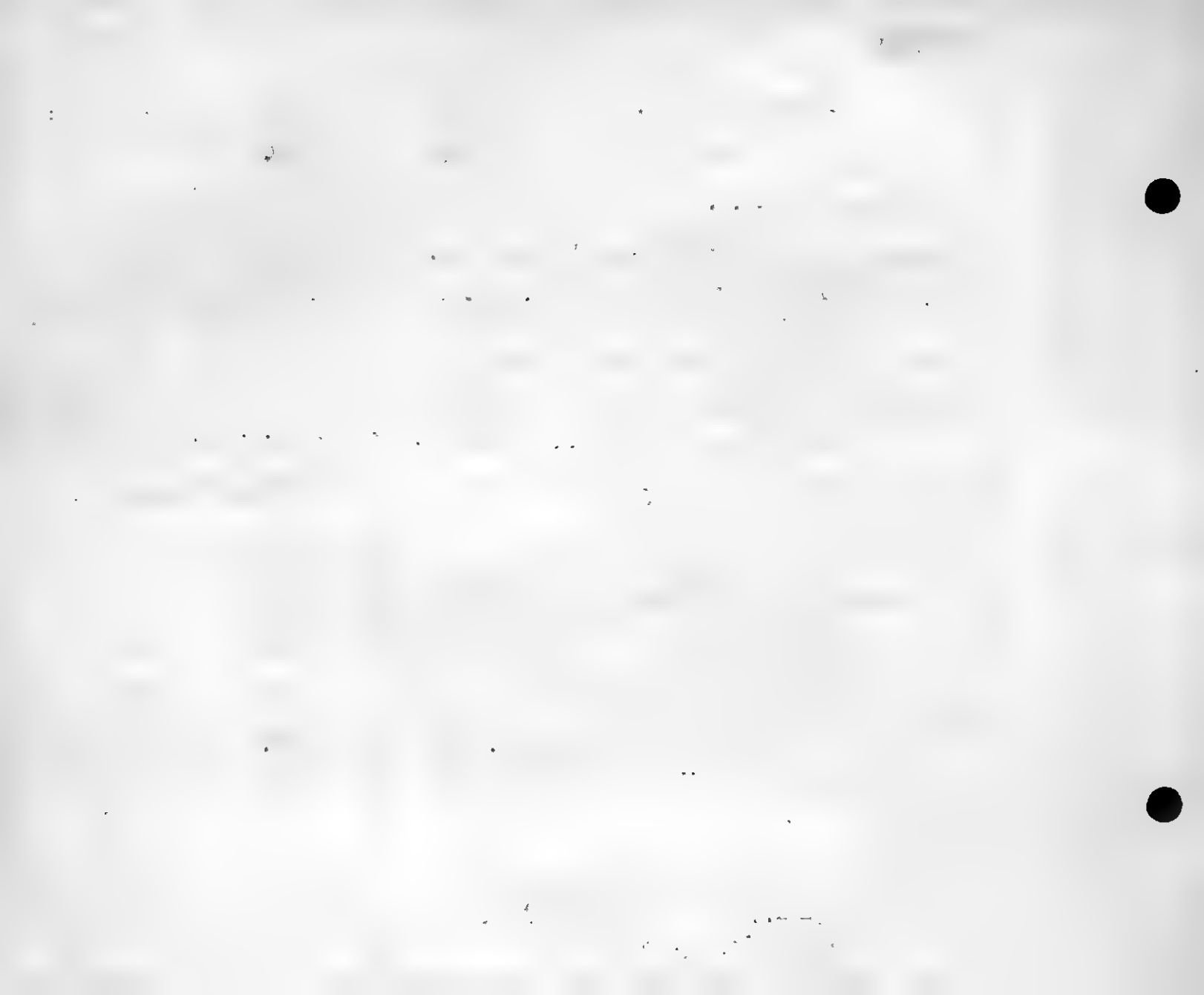
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01400									
01394									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Hilton			R. Costello			Month Day Year			11:40A
3 SEX			4. RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)
Male			White			3/7/94			70
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH
Virginia			U.S.A.						prince George's Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George's General H.			Painter			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?
Maryland			Prince George's			Cap. Heights			YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
First Middle Last			First Middle Last			918 49th Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE, MASSIVE</u>									
431.0 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>HYPERTENSION</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year							
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 31</u> , 19 <u>67</u> , to <u>Jan. 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>John B. Cameron</u>								<u>Jan 7, 1968</u>	
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-9-1968		Washington National		Suitland Maryland			
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
4308 Suitland Road Suitland Maryland						DATE JAN 10 1968		<u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

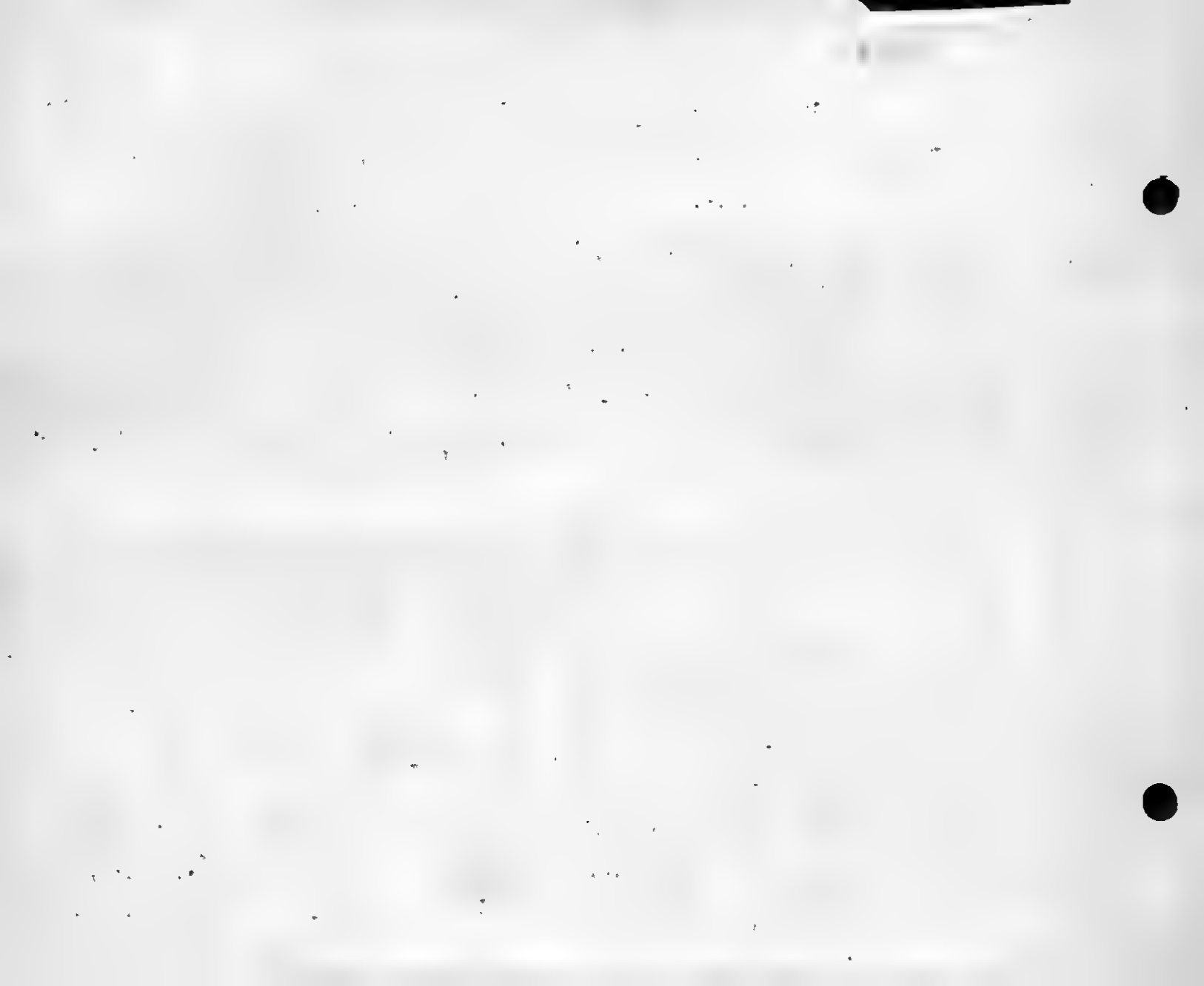
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01395

1 DECEASED-NAME (Type or print) Marie Victorine Cournoyer			2a. DATE OF DEATH Month Jan. Day 10 Year 68			2b. HOUR 2:00 P M					
3. SEX Female		4 RACE White		5. DATE OF BIRTH October 12, 1881		6. AGE (In years last birthday) 86 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.					
10. CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4304 Yucca Street				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Georges		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY & HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4304 Yucca Street			
14. FATHER'S NAME First Francis Middle Mathieu Last Victorine			15. MOTHER'S MAIDEN NAME First Victorine Middle ? Last ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) --			16b. SOCIAL SECURITY NO. 023-07-5161		17. INFORMANT Paul R. Cournoyer			Address Same as 13			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 years DUE TO, OR AS A CONSEQUENCE OF (c) 10 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from December, 1966 , to Jan. 10, 1968 , that (I) (we) last saw the deceased alive on Jan. 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William B. Gunther M.D.				DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED Jan 10, 1968			
22d. PHYSICIAN'S NAME (Type) William B. Gunther M.D.				22e. ADDRESS 4917 Edgewood Road, College Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 13, 1968		23c. NAME OF CEMETERY OR INTERMENT Holy Rosary & St Marys				23d. LOCATION (City or Town) (County) (State) Spencer Worcester Mass.			
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.				25a. RECD. BY REGISTRAR JAN 15 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



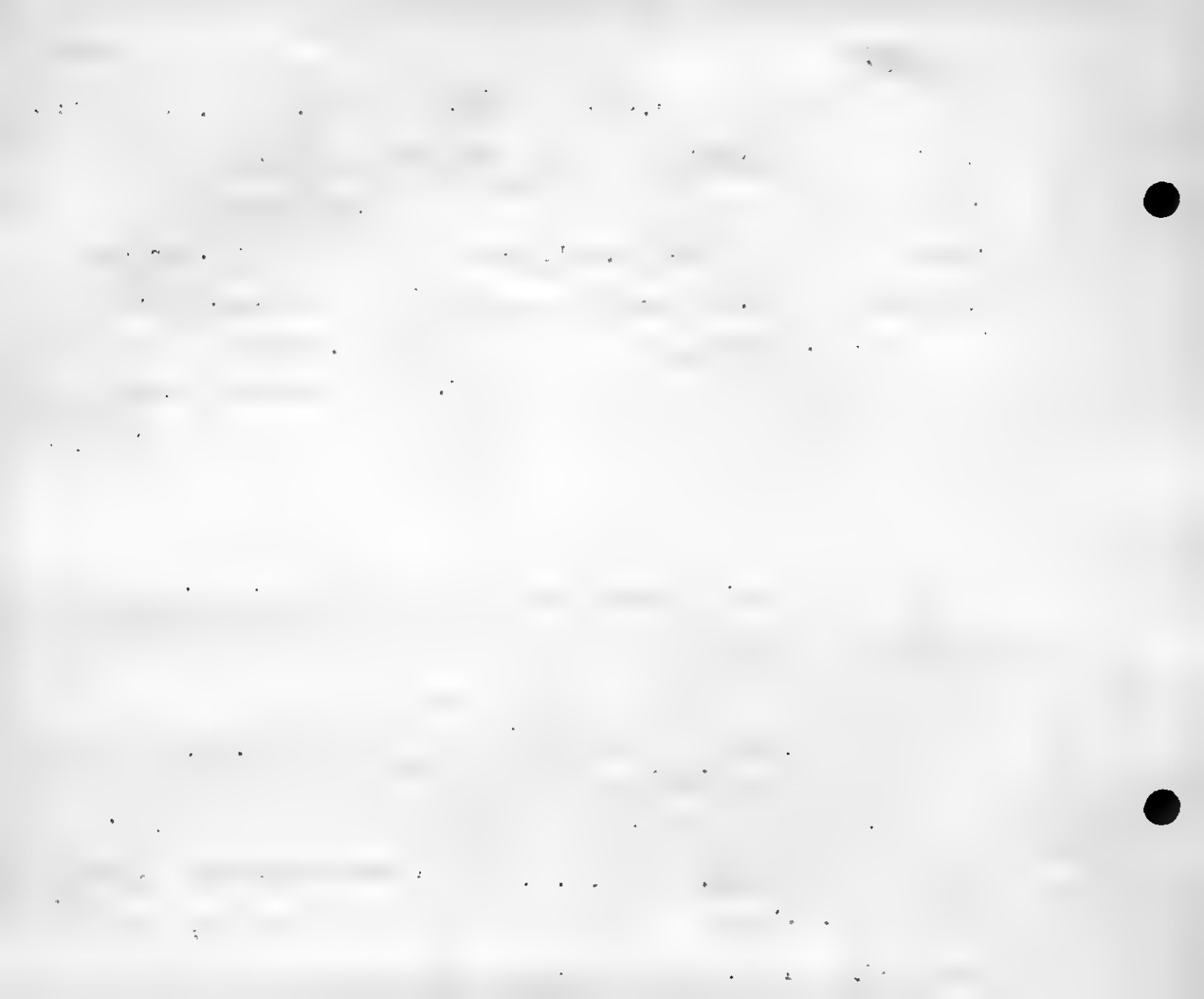
CERTIFICATE OF DEATH

01396

1 DECEASED-NAME (Type or print) Helen Carolyn Currey			2a. DATE OF DEATH Month Jan. Day 24 Year 1968			2b. HOUR 6:15P M					
3 SEX Female		4. RACE caucasian		5. DATE OF BIRTH 8/28/1914		6. AGE (In years last birthday) 53 YRS		7. UNDER 1 YEAR MONTHS DAYS 			
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.					
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Navy Dept. Employee			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b COUNTY Prince Georges		13c CITY OR TOWN Cheverly		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6423 Landover Road		
14 FATHER'S NAME First Harris A. Middle Kimball				15 MOTHER'S MAIDEN NAME First Carrie O. Middle Belvin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO. Unknown		17 INFORMANT Address George J. Currey, Cheverly, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 213X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Myeloma		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease with coronary artery disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the physician) attended the deceased from 11/15/66 to Jan. 24, 1968 , that (I) (the) last saw the deceased alive on Jan. 24, 1968 , and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (I) (the) (did) view the body after death.											
22b. SIGNATURE Frederick H. Wilhelm, M.D.						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/24/68	
22d. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M. D.						22e. ADDRESS 6319 Landover Road, Cheverly, Maryland					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE Jan. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery			23d. LOCATION (City or Town) (County) (State) Federalburg, Maryland			
24. FUNERAL DIRECTOR Freemont Funeral Home Federalburg Md.						ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First Nancy		Middle M.		Last Daras		2a. DATE OF DEATH Month 8, Day 68 Year		2b. HOUR 6:30 A.M.
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH April 21, 1929		6 AGE (In years last birthday) 38 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges				Md.
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. General Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY At Home				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Prince Georges		13c CITY OR TOWN Carmody Hills		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 298 73rd Street		
14. FATHER'S NAME First Middle Last Herbert Lightfoot		15 MOTHER'S MAIDEN NAME First Middle Last Virginia (Unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. None		17. INFORMANT Address Unknown		Same As 13A				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Portal cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Portal cirrhosis</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that he (this hospital) attended the deceased from Jan. 7, 1968, to Jan. 8, 1968, that he (we) last saw the deceased alive on Jan. 8, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (do not) view the body after death.										
22b SIGNATURE <u>Don B. Cameron</u>		22c. ADDRESS Don B. Cameron, M. D.		22d. ADDRESS Prince Georges General Hospital		22e. DATE SIGNED Jan. 1968				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/11/1968		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d LOCATION (City or Town) (County) (State) Suitland, Maryland				
24. FUNERAL DIRECTOR <u>W.W. Chambers</u>		25a. REC'D BY REGISTRAR DATE JAN 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PIN 3. Pages 1, 2, and 3 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) Theodore		First		Middle		Last Davis		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 1-13 68 19:4:35p M		2b. HOUR	
3 SEX Male	4. RACE White	5. DATE OF BIRTH 7-22-1914		6. AGE (In years last birthday) 52 53 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 1 13 68 19 4:35p M	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CIT ZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (Where deceased lived, if not institution admission) STATE Md.		13b. CITY OR TOWN Prince George		13c. INSIDE CITY LIM. IS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 4212 71st. Avenue					
14. FATHER'S NAME Mark		First		Middle Max		Last Davis		15. MOTHER'S M.A.DEN NAME Hallie		First 7 Middle Roberts Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 214 18 0997		17. INFORMANT Dorothy Lee Davis Landover Hills, Md.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of abdomen 765 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1811											
19a. DATE OF OPERATION 1-13-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Gun shot wound of abdomen				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		2 b. TIME OF INJURY Month, Day, Year 12:55am 1-13- 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Shot by assailant							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Lee's Bar		21f. LOCATION Street or R.F.D. No City or Town County State 2903 Hamilton St., Hyattsville, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						22b. DATE SIGNED 1-14-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md		25a. REC'D BY REGISTRAR DATE JAN 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

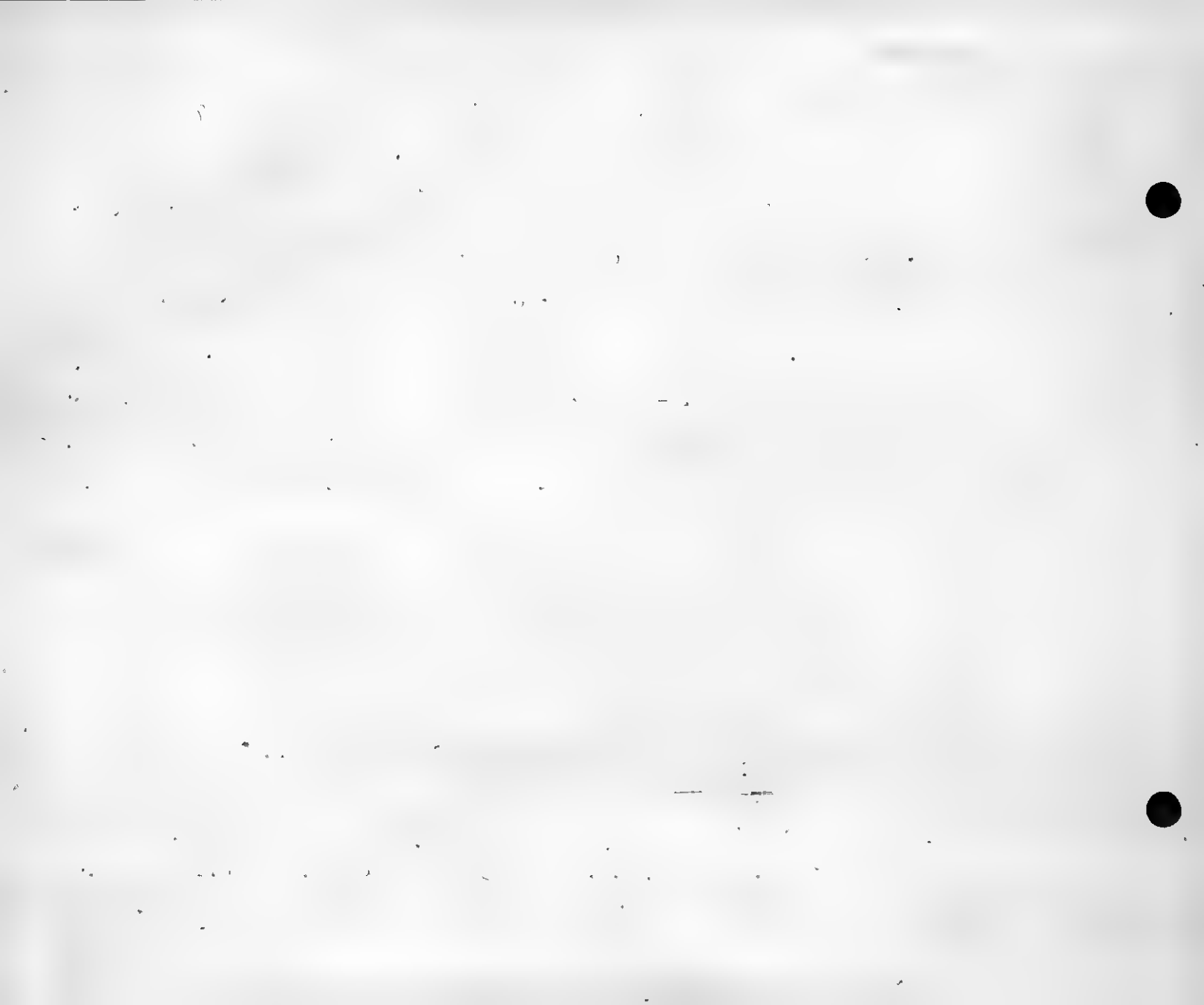


CERTIFICATE OF DEATH

01399

1. DECEASED-NAME (Type or print) Theresa			First A.			Last Davis			2a. DATE OF DEATH Month January Day 7 Year 1968			2b. HOUR 8:20 M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH December 19, 1886			6. AGE (In years last birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerking			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital, residence before admission) STATE Maryland			13b. COUNTY Prince George			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 146 Market Street		
14. FATHER'S NAME First George H. Middle Davis Last Davis			15. MOTHER'S MAIDEN NAME First Mary Middle A. Last BINEAU											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 219-16-0926			17. INFORMANT Sacred Heart Home, Hyattsville, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary thrombosis with myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) four years												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH two days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 410.9														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from October 16, 1964 , to Jan. 7, 1968 , that (I) (we) last saw the deceased alive on January 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Thomas F. Collins M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED January 7, 1968					
22d. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.			22e. ADDRESS 322 H Street, N.E., Washington, D.C.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1-9-68			23c. NAME OF CEMETERY OR CREMATORY St. Marys			23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.					
24. FUNERAL DIRECTOR John M. L. Roberts			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			DATE JAN 10 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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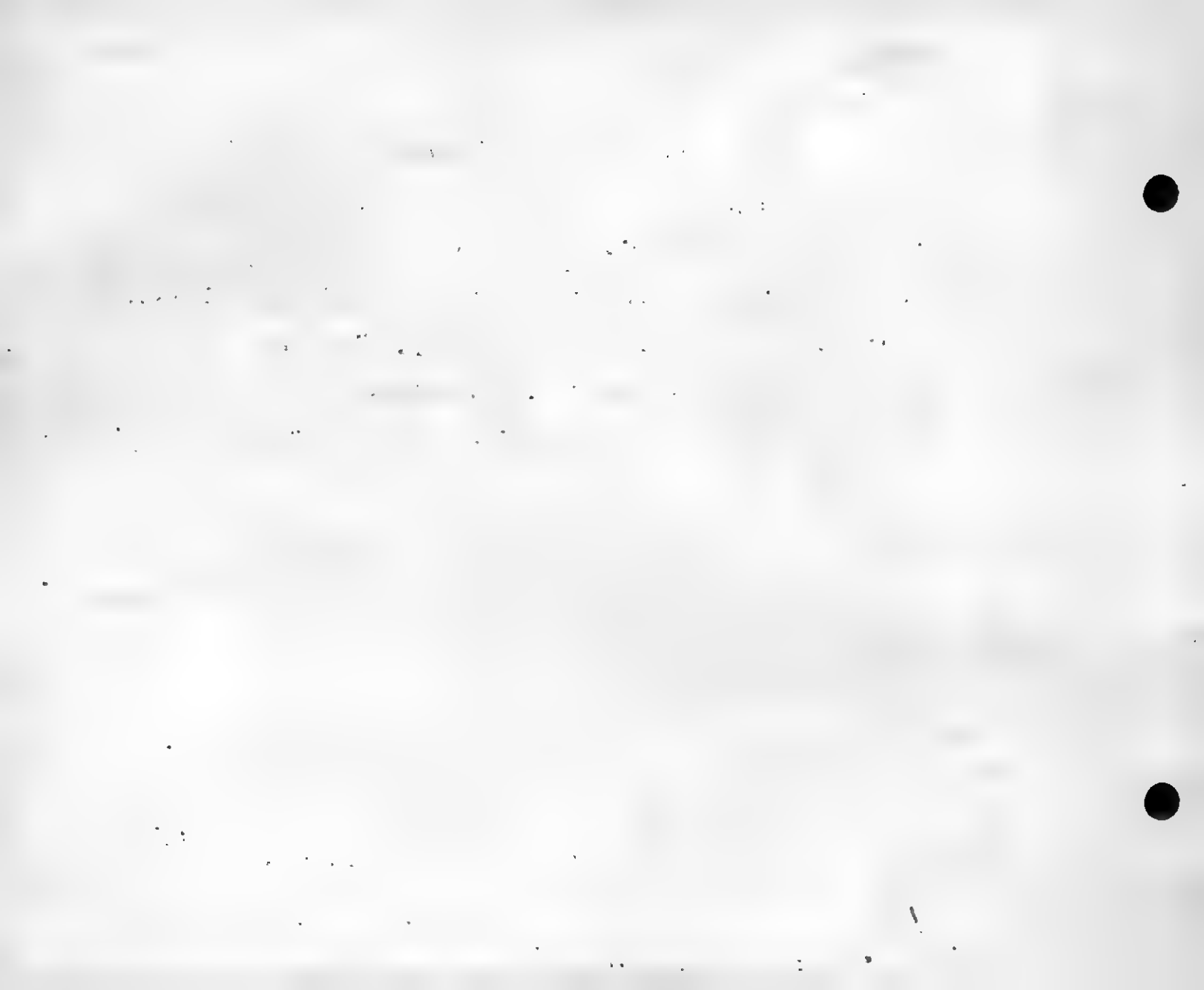
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01406

01400

1. DECEASED-NAME (Type or print) First Middle Last Melvin A Day			2a. DATE OF DEATH Month Day Year 1 23 68		2b. HOUR 7:00 P.M.
3. SEX M	4. RACE White	5. DATE OF BIRTH 3/25/1883		6. AGE (In years last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md.		
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6803 - 30th Ave.	
14. FATHER'S NAME First Middle Last George Day		15. MOTHER'S MAIDEN NAME First Middle Last Ridgley, Virginia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-16-1411	17. INFORMANT Address Prev. Admin.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Gastric ulcer with hemorrhage 10 days</u> 5310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 29, 1966</u> to <u>Jan 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L W Malin		DEGREE M.D.		22c. DATE SIGNED 1/23/68	
22d. PHYSICIAN'S NAME (Type) L W MALIN M.D.		22e. ADDRESS Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVA (Specify) Burial	23b. DATE 1-27-68	23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City or Town) (County) (State) Howard Co Md.	
24. FUNERAL DIRECTOR Arthur H. Stang & Ophelia M. Stang		ADDRESS		25a. REC'D BY REGISTRAR JAN 29 1968	25b. REGISTRAR'S SIGNATURE James J. Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Baby Girl DeHaven			2a. DATE OF DEATH Jan. 9, 1968 Month Day Year			2b. HOUR 8:50AM			
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Jan. 8, 1968		6 AGE (In years last birthday) YRS. MONTHS DAYS 15		IF UNDER 1 YEAR MONTHS DAYS 15	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges		Md	
10. CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4615 Greenwood Road	
14. FATHER'S NAME First Middle Last Harry DeHaven			15. MOTHER'S MAIDEN NAME First Middle Last Mary Geraldine Quinn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none		17. INFORMANT Address Mother) Mary G. DeHaven Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subtentorial Cerebral Hemorrhage, bilateral. 7720 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDINGS, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 8, 1968 , to Jan. 9, 1968 , that (I) (we) saw the deceased alive on Jan. 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <i>William C. Weintraub</i>		DEGREE William C. Weintraub, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan. 9, 1968			
22d. PHYSICIAN'S NAME (Type) William C. Weintraub, M. D.		22e. ADDRESS Professional Bldg., Greenbelt, Maryland							
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE 1-11-68		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City or Town) (County) (State) Gallitzen Cambria Pa			
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JAN 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

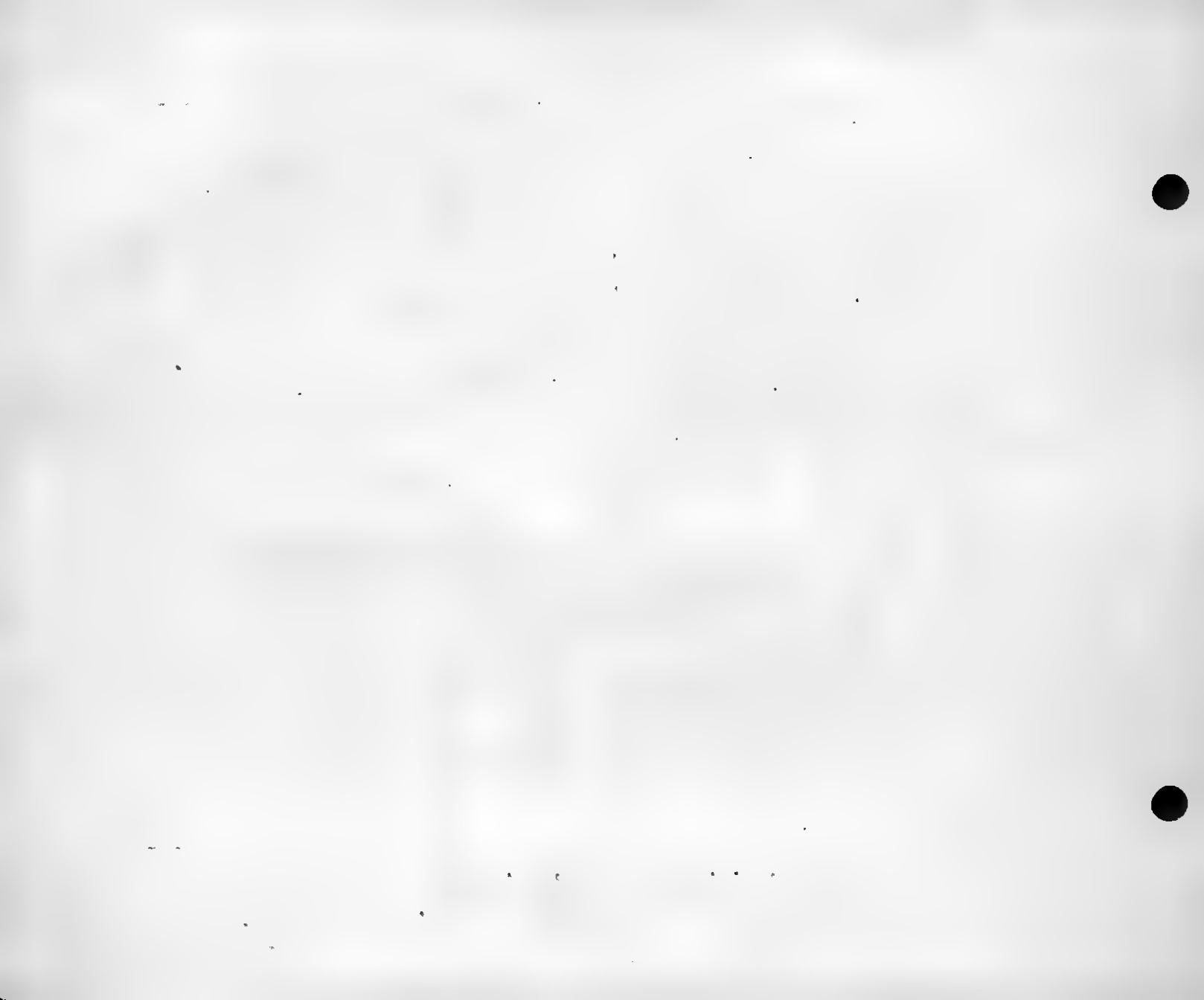
01408

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01402

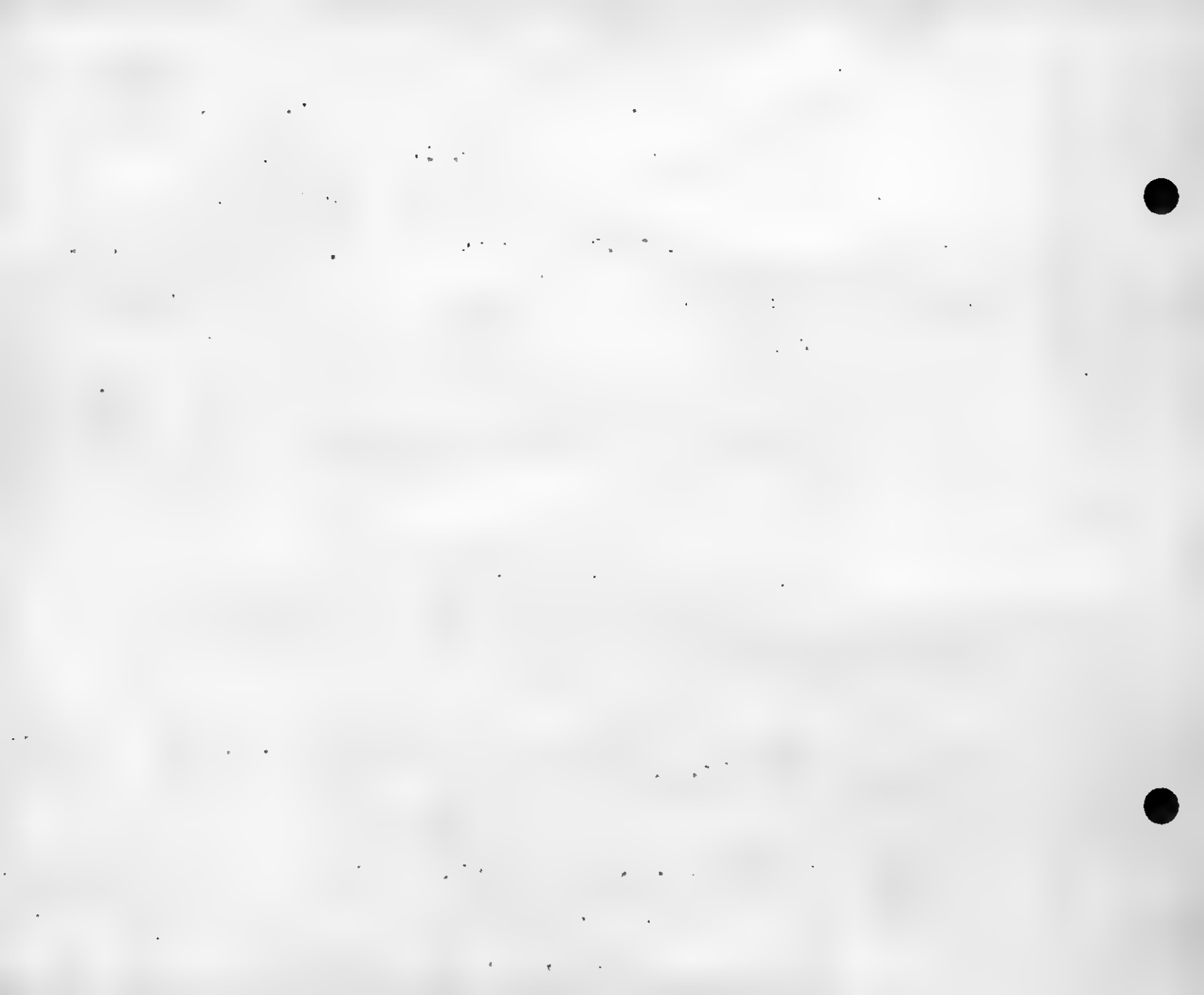
1. DECEASED NAME (Type or Print) First Middle Last Oshin Der Stepanian			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1-5-68 19 5:50aM			2b. HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3 June 1928	6. AGE (In years last birthday) 39 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 1 5 1968 6:10M		
7a BIRTHPLACE (State or foreign country) IRAN		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.		
10 CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Mem. Hospital		12a. LSLA. OCCUPATION (Kind of work done during most of working life, except retired) DOCTOR (MD)		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL		
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Md.		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INS. OF CITY L.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 3835 Hamilton Street		13f. STREET AND NUMBER WEST HYATTSVILLE MD						
14 FATHER'S NAME First Middle Last REUBEN DER STEPIANIAN			15 MOTHER'S MAIDEN NAME First Middle Last AFTANDELIAN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		
16b. SOCIAL SECURITY NO 121-26-2053			17 INFORMANT DR BABGEN MANGASARIAN and Ching Chang Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4101 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4301								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 1-5-68
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-8-1968		23c. NAME OF CEMETERY OR CREMATORY PARK LAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) ROCKVILLE MD		25a. REC'D BY REGISTRAR JAN 9 1968
24. FUNERAL DIRECTOR W.W. Chambers 1400 Chapin St., N.W. Wash.D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
01409										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
George E. Dodson						Jan. 8, 1968		4:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.		
Male		Caucasian		Aug. 20, 1888		79 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
England		U S A.				Prince Georges		retired		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
Cheverly			Prince Geo. Gen'l Hospital			optometrist				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince Georges		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		4012 Kennedy Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Andrew Dodson			Sarah Harrington							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			579 030 774		Nellie G Dodson Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> 4-777 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <u>Dec 1, 1967</u> to <u>Jan. 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan. 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <u>A. Deitz</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-9-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Aaron Deitz, M. D.</u>					22e. ADDRESS <u>PRINCE GEORGES PLAZA, HYATTSVILLE, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Jan 11, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo		Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.					DATE <u>JAN 15 1968</u>		<u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 7a & 7a Film G397

01404

DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF EST. DEATH		Month	Day	Year	2b. HOUR
Robert		M	Donald		DATE MATED		1-22-68	19	10:30	am
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	White	9-25-1931	36 YRS	MONTHS	DAYS	HOURS	MIN	Month	Day	Year
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Washington, DC		USA				Prince George's				MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. U.S.A. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
District of Columbia		Washington				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1201 B Street, N.W.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
JOHN W. DONALD					CATHERINE H. HARRINGTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or Unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
No		579402348		JOHN W. DONALD		2703 Webster St. MOUNTAIN VIEW, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Acute intoxication ethyl alcohol										
303.4 DUE TO, OR AS A CONSEQUENCE OF 0.47%										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		John Kehoe, M.D.		Riverdale, Md.		22b. DATE SIGNED		1-24-68
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		26 JAN 1968		MT. OLIVET CEMETERY		WASHINGTON, D.C.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
W.W. CHAMBERS CO. RIVERDALE, MD.				DATE JAN 30 1968		John Kehoe				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

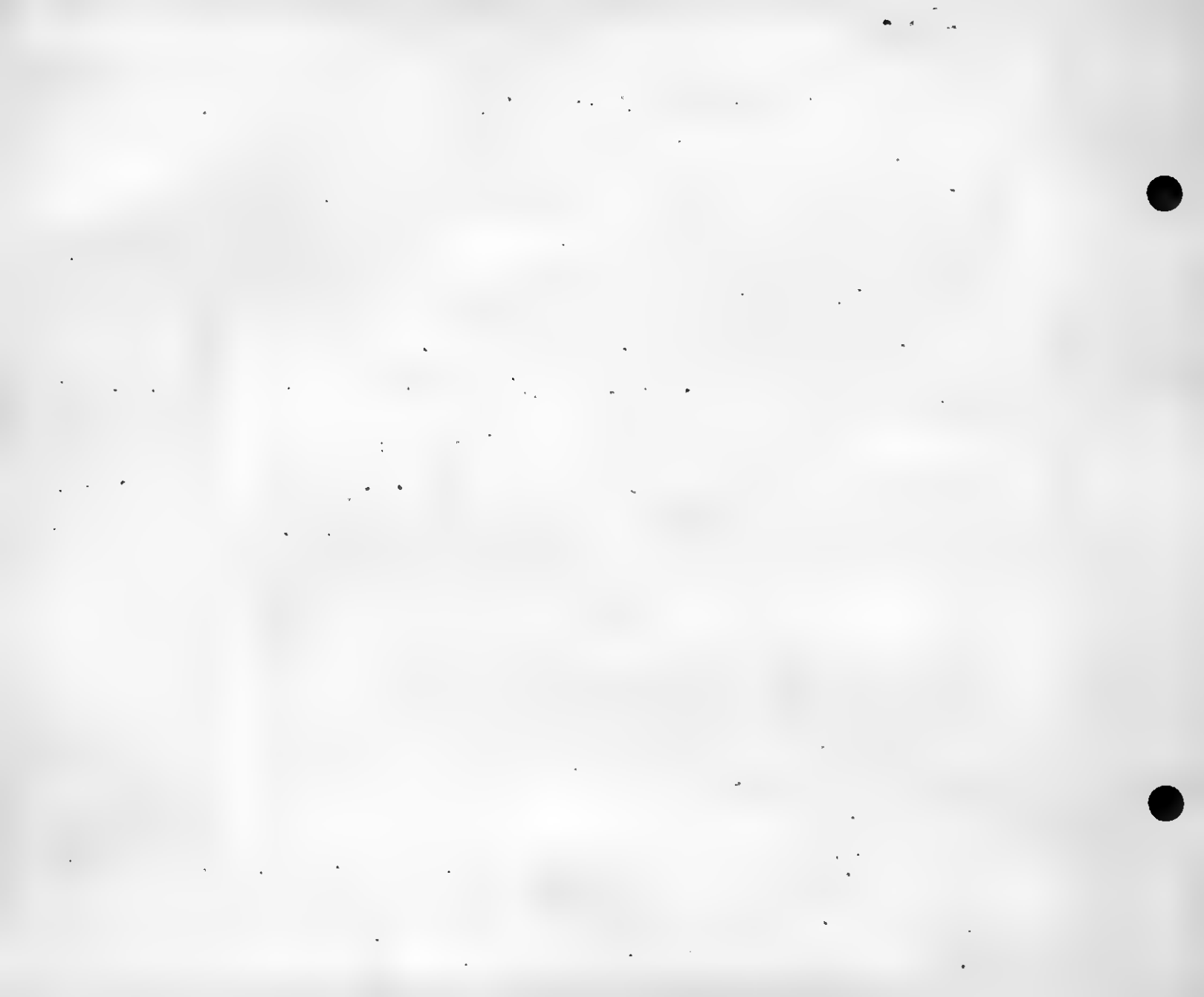
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

014055

1. DECEASED NAME (Type or print) KATHRYN S. DONALDSON			2a. DATE OF DEATH Month 1 Day 23 Year 1968			2b. HOUR 2:55 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-19-1917		6. AGE (in years last birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) GA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEO'S Md.	
10. CITY OR TOWN OF DEATH CHELENHAM		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE GEO'S		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY PRINCE GEO'S		13c. CITY OR TOWN CHELENHAM		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER BOX #32		14. FATHER'S NAME First JOHN Middle R Last SANDERS		15. MOTHER'S MAIDEN NAME First NEGGIE Middle — Last —			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT JAMES A DONALDSON		Address Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia & Weakness DUE TO, OR AS A CONSEQUENCE OF (b) Generalized carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Rt Breast							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years 13 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 11							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1955 to Jan 23, 1968 , that (I) (we) last saw the deceased alive on 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W.W. Eastman				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 23, 1968	
22d. PHYSICIAN'S NAME (Type) W.W. EASTMAN				22e. ADDRESS 831 University Blvd E. S.S. Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-26-1968		23c. NAME OF CEMETERY OR CREMATORY Wash Hall Cemetery		23d. LOCATION (City or Town) (County) (State) Southland Md.	
24. FUNERAL DIRECTOR W.W. Chambers Co				ADDRESS 517-11 St SE Wash DC		25a. REC'D BY REGISTRAR DATE Jan 29 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

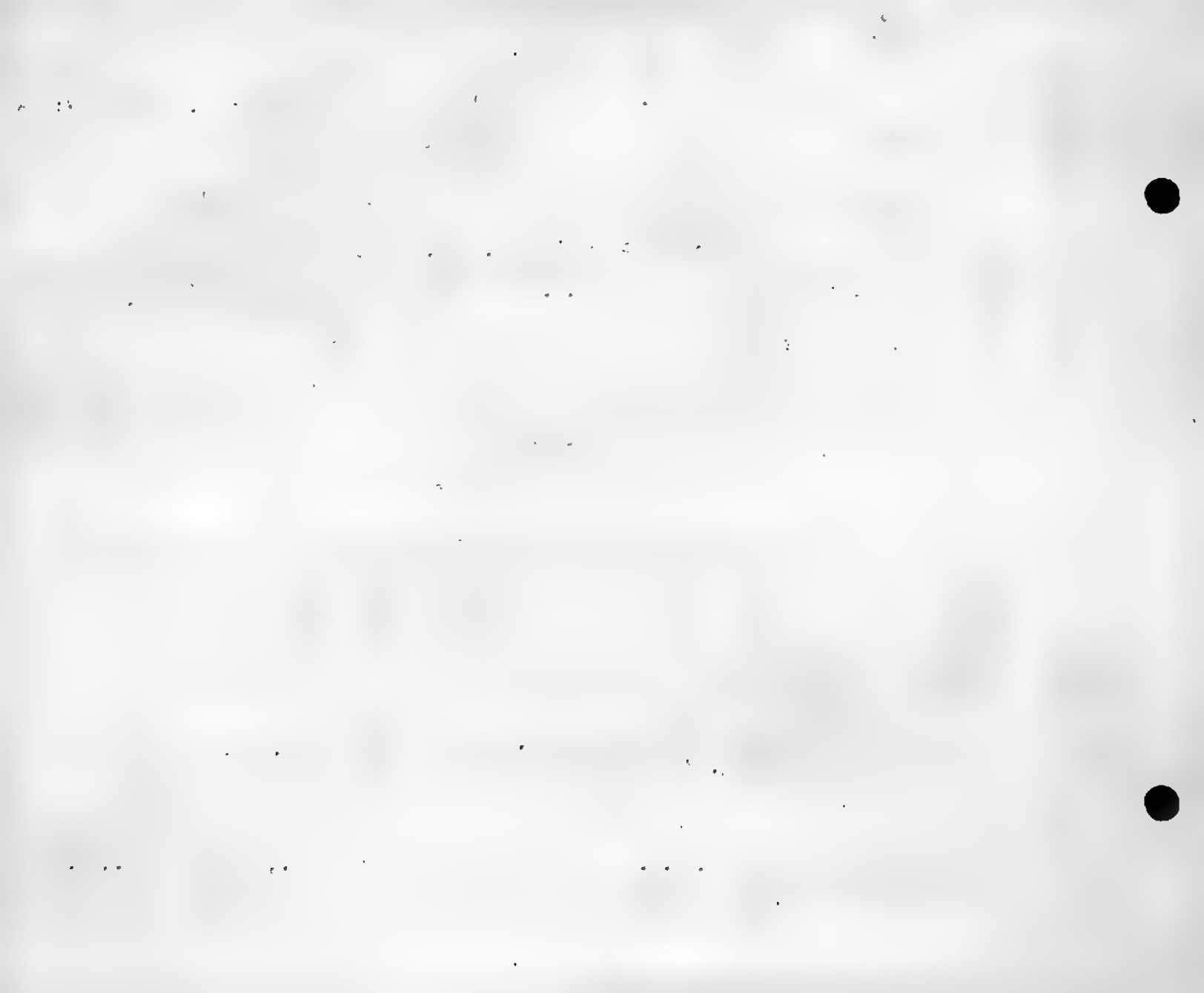


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VA 15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
01412																							
01406																							
1. DECEASED-NAME (Type or print)			First Bess			Middle R.			Last Dresner			2a. DATE OF DEATH Month January			Day 20			Year 1968			2b. HOUR 9:35 AM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 12/3/91			6. AGE (In years last birthday) 76			IF UNDER 1 YEAR MONTHS YRS			IF UNDER 24 HRS HOURS MIN								
7a. BIRTHPLACE (State or foreign country) Russia			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's										Md.				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Social Worker			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York			13b. COUNTY N.Y. City			13c. CITY OR TOWN N.Y. City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 351 West 24th St.			13f. STREET AND NUMBER Gertrude Salk								
14. FATHER'S NAME Abraham Salk			First Middle			Last Unknown			15. MOTHER'S MAIDEN NAME Unknown			First Middle			Last Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Allan R. Dresner			Address Son. 7026 Wyndale			SH. H. W.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Cerebral Vascular Disease (b) Cerebral Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331x																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC.			21f. LOCATION Street or R.F.D. No City or Town County State																	
22a. I certify that (I) the hospital attended the deceased from April , 1966, to Jan. 20 , 1968, that (I) (we) last saw the deceased alive on Jan. 20 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Peter Duus			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1/20/68								
22d. PHYSICIAN'S NAME (Type) Peter Duus, M.D.			22e. ADDRESS 6124 Central Ave., Capitol Hgts., Md.																				
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE 1/20/68			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City or Town) (County) (State) Southland PA Geo Co Md														
24. FUNERAL DIRECTOR Bernard A. Hanzon			ADDRESS 4150 N. 35th St. York			25a. REC'D BY REGISTRAR DATE JAN 23 1968			25b. REGISTRAR'S SIGNATURE Charles J. Jones														



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01413

MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01407

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			ESTIMATED <input type="checkbox"/> Month Day Year			2b. DATE OF DEATH			ESTIMATED <input checked="" type="checkbox"/> Month Day Year								
John Elden Dunn						2c. DATE PRONOUNCED DEAD			Month Day Year			2d. HOUR			11 AM								
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
male		white		May 12, 1882		85 YRS		MONTHS DAYS		HOURS MIN.		Md		U S A				Prince George's Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly				Prince George's Hosp. - DOA				Retired Salesman				Real estate											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission, STATE)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER							
Maryland				Prince George's				Beltsville				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				10906 Fleetwood Drive							
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last														
Stewart Dunn						Marjorie Beveridge																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
no						578 18 7991			Edith W Eberhart			Arlington Va.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure												minutes											
4121 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) Arteriosclerotic heart disease											
												unknown											
(c) DUE TO, OR AS A CONSEQUENCE OF																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
42																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED											
EXAMINER'S NAME (Type)						ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>						1-2-68											
John Kehoe, Md.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						Riversdale, Md. (county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)					
Burial						Jan 4, 1968						Ft Lincoln Cemetery						Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR						ADDRESS						25a. RECD BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons						Hyattsville, Md.						JAN 8 1968						Charles Judge					



01414

CERTIFICATE OF DEATH

01408

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE D. C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 1 yr., 5 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1122 Holbrook St., N. E.	
3 NAME OF DECEASED (Type or print) Clarence E. Edwards		4. DATE OF DEATH Month 1 Day 2 Year 19 68	
5 SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/23/1908
9 AGE (In years last birthday) yrs. 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	
11 BIRTHPLACE (County & State, or foreign country) Florida		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Edwards		14. MOTHER'S MAIDEN NAME Josephine ??	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 265-16-5385	
17 INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident (probably thrombosis) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour unknown unknown	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART .(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 7/29/ 19 66 , to 1/2/ 19 68 , that the (we) last saw the deceased alive on 1/2/ 19 68 , and that death occurred at 7:30 A.M. , from causes and on the date stated above.			
22a SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED 1/2/1968	
22c PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 1-6-68	
23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d LOCATION (City or Town) (County) (State) Prince George, Maryland	
24 FUNERAL DIRECTOR <i>John T. Rhine Co</i>		25a. REC'D BY REGISTRAR JAN 8 1968	
25a REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01409									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
ROBERT			M ERNEST			Jan 28 1968		12:50 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		F UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		July 14, 1927		40 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ala		U S A				Prince George Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo Gen Hosp			D C Govt		6	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md			Prince George Hyattsville				5507 Gallatin St		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles E. Ernest			Claudia L. Dickerson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
					Charles H. Ernest				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> <u>571.8</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatic Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>67</u> , to <u>1/28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Barry Kumbey</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-1-68		Cedar Hill Cem.		Suitland, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Lee Funeral Home, 300-4th St. N.E. Wash, D.C. 20002					1 1968		<u>Charles Judge</u>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files.

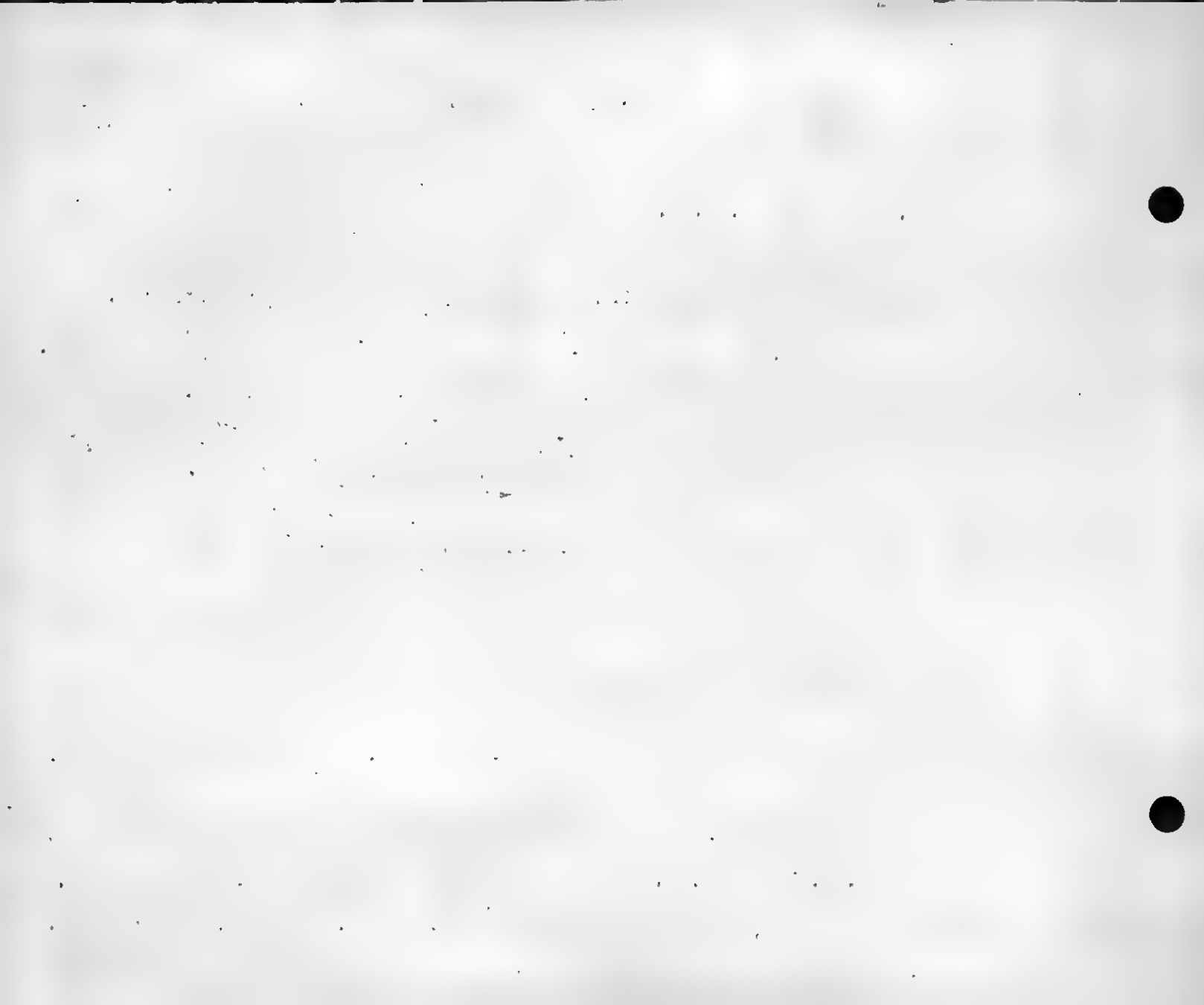
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Richard Evans						Month Day Year		12:45 p.m.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	7 UNDER YEAR	8 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	Neuro	8 April, 1917	50 YRS	MONTHS	DAYS	Month Day Year		1:10 p.m.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia						Prince George		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
			1211-Eastend Ave 7E						
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER	
Md			Prince George			YES <input type="checkbox"/> NO <input type="checkbox"/>		1211 Eastern Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			
						Bertha P. Evans, 1211-Eastend Ave 7E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								Heart failure	
4129 DUE TO, OR AS A CONSEQUENCE OF								Minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Arteriosclerotic heart disease								Unknown	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4200									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
		19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		120-68	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
		1-27-1968		Harmony Mem.		Prince Geo. Co.		Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Laluy Funeral Home		3831 La Grange Rd		DATE JAN 26 1968		James J. Judge			

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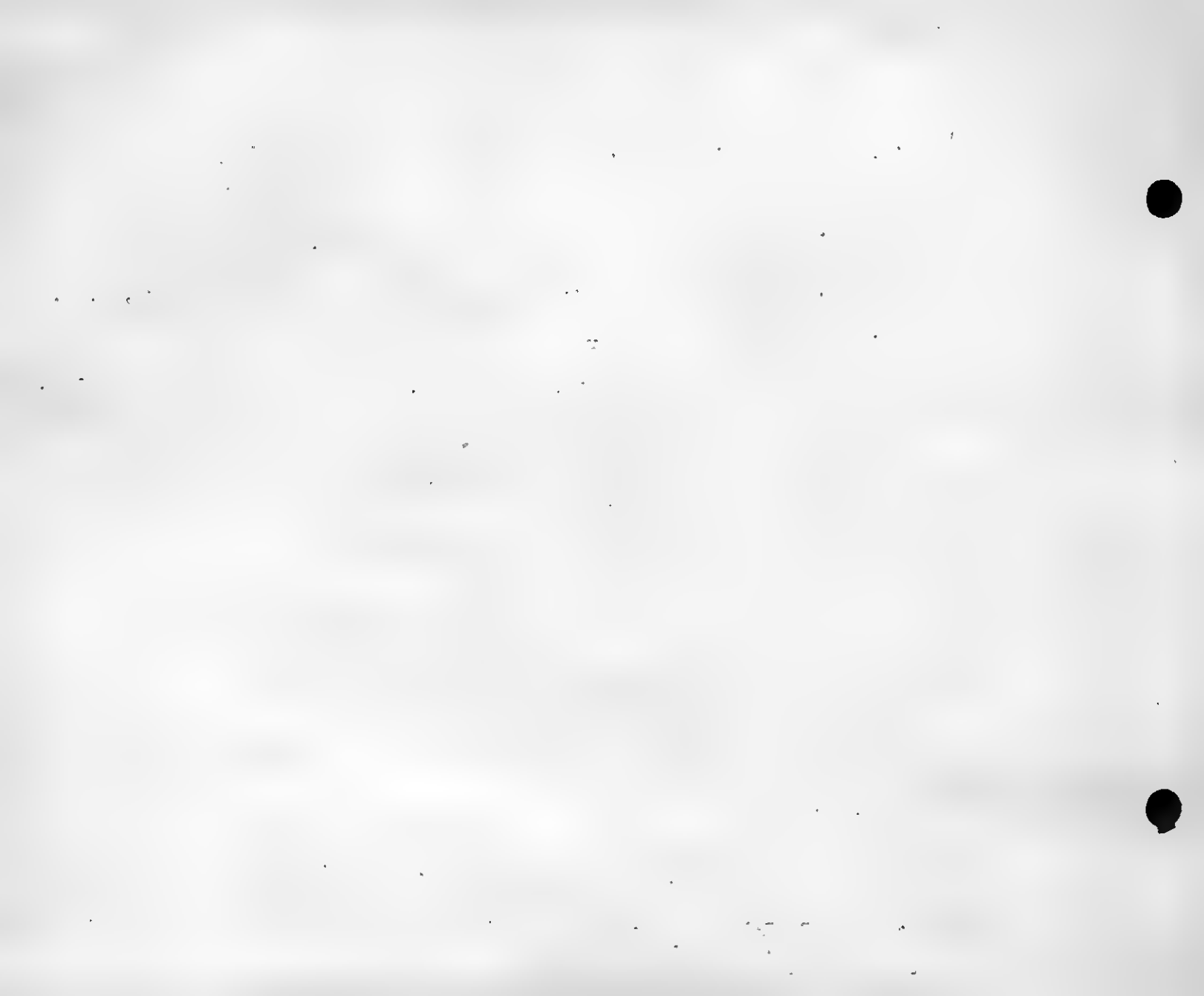
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																										
Items 5 & 6 Film G397 1/24/68 kk																										
CERTIFICATE OF DEATH																										
01411																										
1. DECEASED-NAME (Type or print)			First Sterling			Middle Frederick			Last Sterling Evans			2a. DATE OF DEATH Month Day Year Jan 10 1968			2b. HOUR 935 P.M.											
3. SEX Male			4. RACE White			5. DATE OF BIRTH 9-18-1910			6. AGE (in years last birthday) 50 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			8. IF UNDER 24 HRS. HOURS MIN											
7a. BIRTHPLACE (State or foreign country) Pa.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Georges			10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pipe fitter			12b. KIND OF BUSINESS OR INDUSTRY Washington Terminal					
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE Maryland			13b. COUNTY Prince Georges			13c. CITY OR TOWN Landover			13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 7504 Maryland Blvd.			14. FATHER'S NAME First Middle Last Fred Evans			15. MOTHER'S MAIDEN NAME First Middle Last Josephine Kennedy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 211 10 4159			17. INFORMANT Viola Evans			Address Landover, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 412x DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure (b) DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic heart disease (c) Emphysema			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4															19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from April 14, 1967, to Jan 10, 1968, that (I) (we) saw the deceased alive on Jan 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22b. SIGNATURE L. W. Malin MD			22c. DATE SIGNED Jan 11, 1968			22d. PHYSICIAN'S NAME (Type) L. W. Malin, M. D.			22e. ADDRESS 4404 Queensbury Road, Riverdale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan 15, 1968			23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			24. FUNERAL DIRECTOR F. Jasch's Sons			25a. REC'D BY REGISTRAR DATE JAN 15 1968			25b. REGISTRAR'S SIGNATURE Charles J. Juge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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014119										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										014112			
CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or print) Ida M Fischer Fisher										2a. DATE OF DEATH Month 1 Day 20 Year 68										2b. HOUR 2:40 P.M.			
3. SEX Female			4. RACE White			5. DATE OF BIRTH 1-23-1888			6. AGE (In years last birthday) 79 YRS.			F. UNDER 1 YEAR MONTHS			F. UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Germany			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.														
10. CITY OR TOWN OF DEATH Forestville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia			13b. CITY OR TOWN Washington			13c. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2212 31st Place, S. E.														
14. FATHER'S NAME First Hugo Middle Kessler Last Young			15. MOTHER'S MAIDEN NAME First Aline Middle Jung Last Young																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 579-60-1874			17. INFORMANT Address Eleanor W. Fischer 2212 31st Place SE DC																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure. DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4.																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19 1968 , that (I) (we) last saw the deceased alive on 16 Jan 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE J. H. Tribadeau M.D.			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 20 Jan 68								
22d. PHYSICIAN'S NAME (Type) J. H. Tribadeau			22e. ADDRESS 3112 AIA. Ave. SE.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-23-1968			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland PG Maryland														
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home ADDRESS 4308 Suitland Road Suitland Maryland										25a. REC'D BY REGISTRAR DATE JAN 25 1968				25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Myrtle Jane Fitzsimmons						Jan. 28, 1968			7:50P M	
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Female	White		Feb. 16, 1883			84 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		U. S. A.				Prince Georges Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Housewife		Own Homo		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince Georges		Capital Hgts.				6216 Highmont Lane	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
Theodore --					Carl	Ellen --			Boyer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
No						William Henry Fitzsimmons-			Same as 13c 13E	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction; posterior and in-</u>										
4109 DUE TO, OR AS A CONSEQUENCE OF <u>terseptum.</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) <u>Severe coronary arteriosclerosis.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Generalized arteriosclerosis.</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the coroner) attended the deceased from <u>1-28-1968</u> to <u>Jan. 28, 1968</u> , that (I) (and) last saw the deceased alive on <u>Jan. 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Oliver B. Bond									1-29-68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
OLIVER B. BOND					6872 Riverdale Road, Lanham, Maryland 20801					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/31/68		Cedar Hill Cemetery		Suitland P.G. Md.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ritchie Bros. Upper Marlboro, Md.							DATE FEB 7 1968			

U.S.

XXIX

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11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

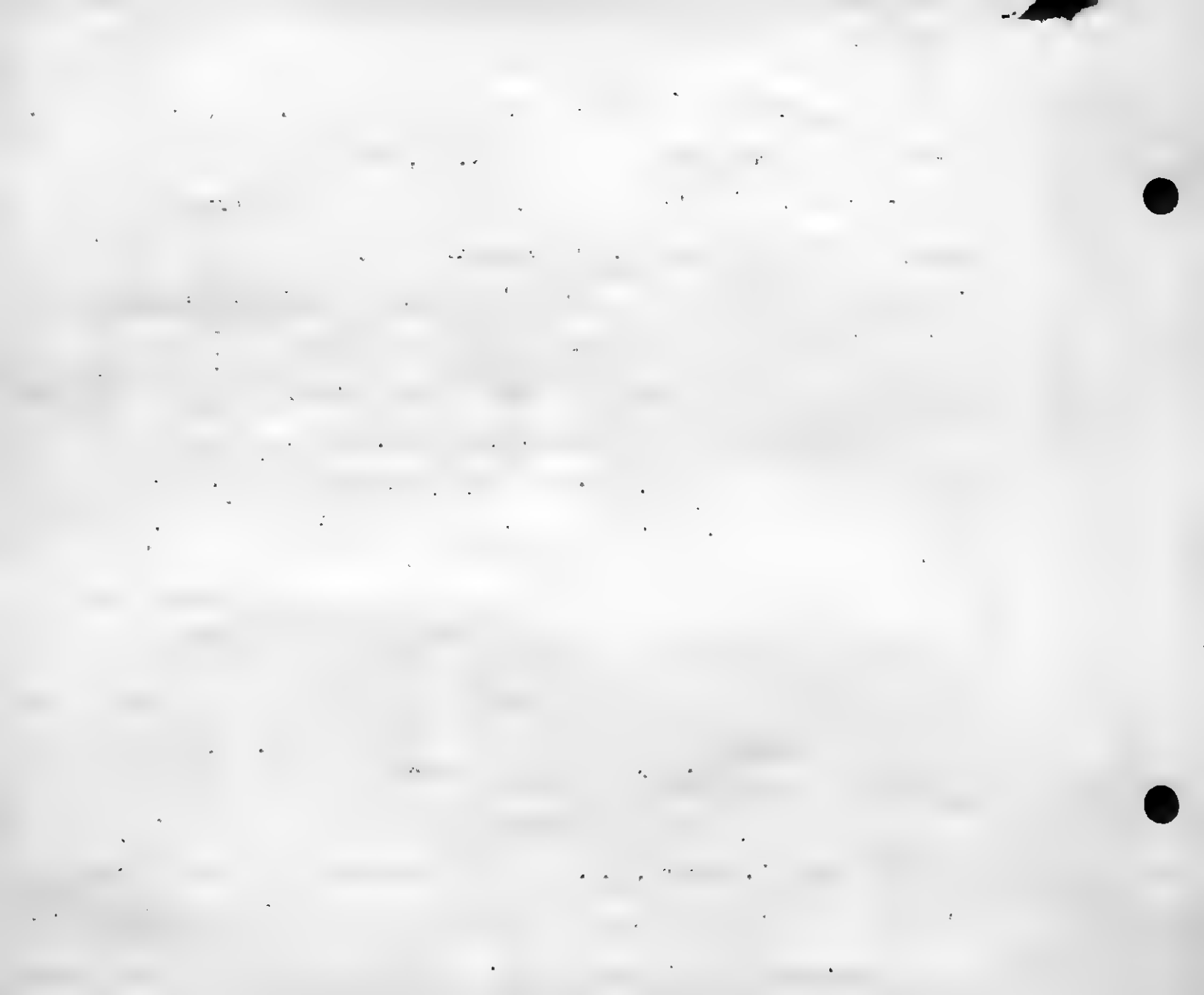
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

31420

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01414

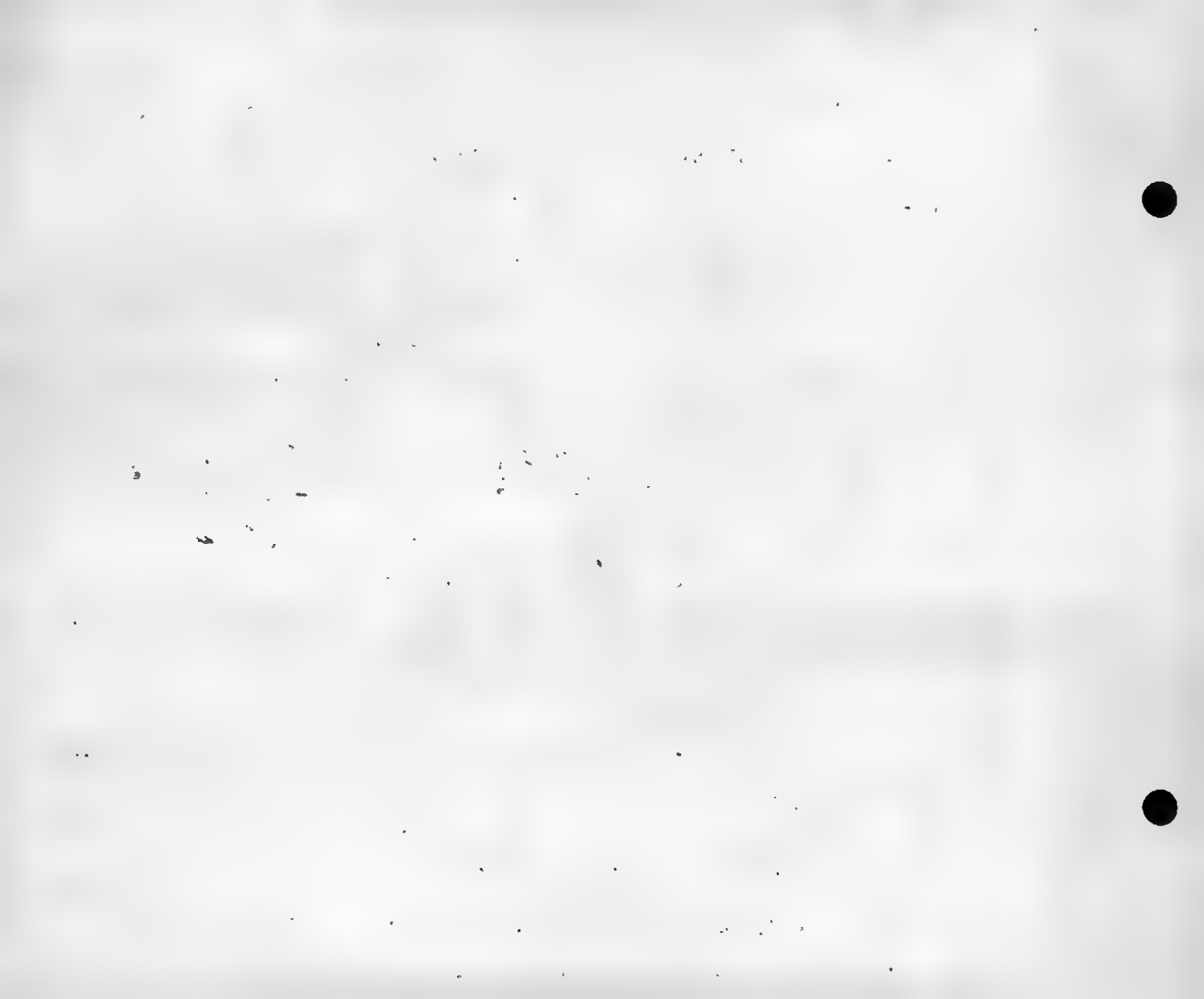
1 DECEASED-NAME (Type or print) First Middle Last Antonia ISABEL Font			2a. DATE OF DEATH Month Day Year Jan. 30, 1968			2b HOUR 7 P. M.			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH Dec. 20, 1996		6 AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) ARGENTINA		7b CITIZEN OF WHAT COUNTRY? ARGENTINA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md.			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY ✓		13c CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6302 Brenmarl Drive	
14 FATHER'S NAME First Middle Last ANTONIO GONZALEZ			15 MOTHER'S MAIDEN NAME First Middle Last ANA SLISSER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. NOVE.		17. INFORMANT MISS LUZ M. RIVERA Address 1816 CURCUMAN ST. N.W. DC				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) generalized edema DUE TO, OR AS A CONSEQUENCE OF (c) bradycardia, fever, etiology unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 47									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (the coroner) attended the deceased from Jan. 30, 1968 , to Jan. 30, 1968 , that (I) (we) saw the deceased alive on Jan. 30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE James W. Harding, M.D.				22c. DATE SIGNED 1/31/68		22d. PHYSICIAN'S NAME (Type) James W. Harding, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/2/68		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION (City or Town) (County) (State) BLADENSBURG. PRINCE GEORGES. MD.		23e. REGISTRAR'S SIGNATURE W. H. Chamberlain	
24. FUNERAL DIRECTOR W. H. Chamberlain				25a. RECEIVED BY REGISTRAR FEB 6 1968		25b. REGISTRAR'S SIGNATURE W. H. Chamberlain			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Carrie			D. Ford			January 23, 1968			M
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Colored		1/11/83		85 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		USA				Pr Geo Co Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		Regent Nursing Home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY (A.M.T.S?)		13e. STREET AND NUMBER	
Maryland		Pr. George		Upper Marlboro		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 86	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Addison Stewart			unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
					Gracie Ford-daughter 3837 Church St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Marked Emaciation & Dehydration to wks</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ex. of Left Femur & Pelvis 2 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Anterior circulation Heart Disease & Senility</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, nat'l med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				Natural causes					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/16, 1968</u> to <u>1/23, 1968</u> , that I saw the deceased alive on <u>1/23, 1968</u> and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Kelvin L. Minchin</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/23/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>KELVIN L. MINCHIN</u>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/26/68		Union Methodist Church		Upper Marlboro, Md.			
24 FUNERAL DIRECTOR <u>John T. Stewart, Jr.</u>		ADDRESS <u>Stewart Funeral Home-4001 Benning Rd.</u>		25a. REC'D BY REGISTRAR <u>DAW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 26 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of a death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01422

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01416

1. DECEASED-NAME (Type or print) William Ford			2a. DATE OF DEATH Jan. Month 7, Day 68 Year			2b. HOUR 7 P. M.			
3 SEX Male		4 RACE Negroid		5. DATE OF BIRTH Feb. 16, 1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased addressed) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Seat Pleasant		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 519 62nd Place	
14. FATHER'S NAME First Middle Last unknown			15. MOTHER'S MAIDEN NAME First Middle Last unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 218-20-0174A.		17. INFORMANT wife		Address same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastric carcinoma with liver metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 15									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 24, 1967 to Jan. 7, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Jan. 7, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE Frederick H. Wilhelm				DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/5/68	
22d. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M. D.				22e. ADDRESS Prince Georges General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-11-68		23c. NAME OF CEMETERY OR CREMATORY St. Luke Cem		23d. LOCATION (City or Town) (County) (State) Forestville Md			
24. FUNERAL DIRECTOR ADDRESS Rollins 4339 - Hunt PL NE				25a. REC'D BY REGISTRAR DATE JAN 10 1968		25b. REGISTRAR'S SIGNATURE J. Charles J...			

THE UNIVERSITY OF CHICAGO

CERTIFICATE OF DEATH

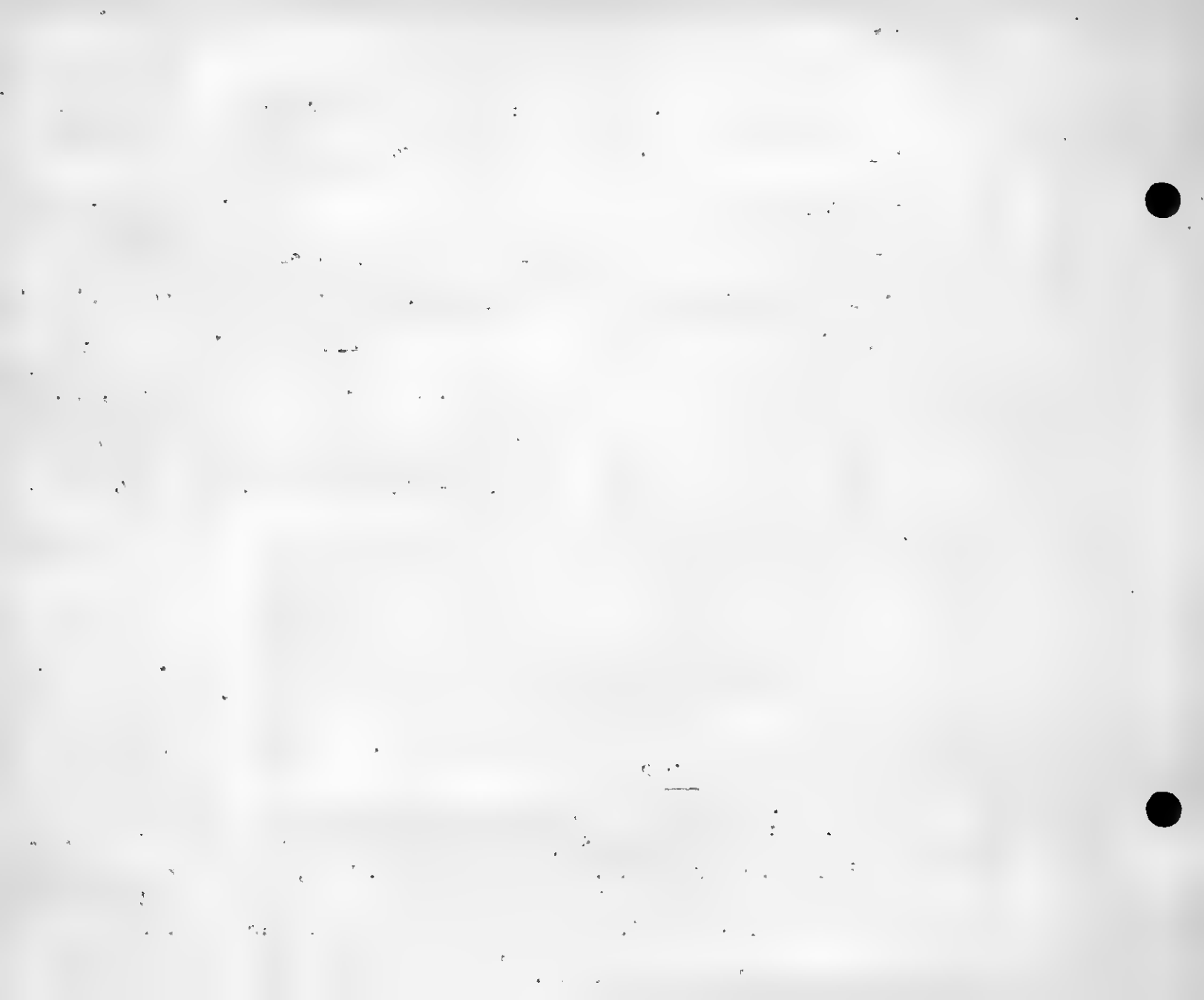
01423

01417

1. DECEASED-NAME (Type or print) First Middle Last May D. Fox			2a. DATE OF DEATH Month Day Year January 6 1968			2b. HOUR A.M. or P.M. 8:40 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 9, 1876		6. AGE (In years last birthday) 91 YRS.	
7a. BIRTHPLACE (State or foreign country) District of Columbia United States		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Milliner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3426 16th Street, N.W.		14. FATHER'S NAME First Middle Last Samuel B. Fox		15. MOTHER'S MAIDEN NAME First Middle Last Ellen M. Egan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. _____		17. INFORMANT Sacred Heart Home		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 6 years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 9, 1962, to Jan. 6, 1968, that (I) (we) last saw the deceased alive on January 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas F. Collins M.D.				DEGREE M.D.		22c. DATE SIGNED January 6, 1968	
22d. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.				22e. ADDRESS 322 H. St. N.E., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/10/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wisconsin Ave, NW Washington, D.C.				25a. REC'D BY REGISTRAR DATE JAN 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 23b Film G398 2/28/68 kk						CERTIFICATE OF DEATH			01418		
1. DECEASED-NAME (Type or print) First Middle Last Robert A. Fredin						2a. DATE OF DEATH Month 1 Day 29 Year 68			2b. HOUR M		
3. SEX male		4. RACE white		5. DATE OF BIRTH 4-30-01		6. AGE (In years last birthday) 66 YRS.		7. UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Wis.		7b. CITIZEN OF, WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges County Md					
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hosp.			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Retired Navy Dept.			12b. KIND OF BUSINESS OR INDUSTRY Supervisor		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5009 Quebec Street		
14. FATHER'S NAME First Middle Last John Fredin				15. MOTHER'S MAIDEN NAME First Middle Last Augusta A Paulson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No				16b. SOCIAL SECURITY NO 701 09 9115		17. INFORMANT Address Spouse					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 20 MIN.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PULM. EMPHYSEMA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from SEP. 1964, to 29 JAN. 1968, that (I) (we) last saw the deceased alive on 29 JAN. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C.J. Holmann					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 29 JAN 68		
22d. PHYSICIAN'S NAME (Type) C.J. HOLMANN M.D.					22e. ADDRESS RIVERDALE MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Feb 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.				
24. FUNERAL DIRECTOR F. Gasch's Sons					ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 2 1968		25b. REGISTRAR'S SIGNATURE		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Wanda Freeland						ESTIMATED <input checked="" type="checkbox"/> Month Day Year			10pm
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Female	Negro	4 Feb. 1965	2 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	5:10pm
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland						Prince George's Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital						
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.			Prince George's			YES		7401 D. Street	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James Freeland			Hazel Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						Mother 7401 D.St. Carmondy Hill			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Irreversible brain damage									
DUE TO, OR AS A CONSEQUENCE OF Asphyxia									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) From occlusion of airway by balloon fragment									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
925									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			1:45pm 1-17-1968						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State			
			Bedroom of home			same as #13			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			1-19-68			
John Kehoe, M.D. Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
			1-22-68		Patuxent Ch. Cem		Huntingtown Cal. Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Linkney E. Swell			Prince Fred. Md			DATE JAN 29 1968			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01420					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First Gladys			Middle S.			Last Funkhouser			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 5 Year 1968		2b. HOUR 10:45	
3 SEX female		4 RACE white		5 DATE OF BIRTH 5-13-07		6 AGE (in years last birthday) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 1 Day 5 Year 1968		2d. HOUR 10:45	
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CT ZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's				pm		
10. CITY OR TOWN OF DEATH Camp Springs				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrew's Air Force Base Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of work week, even if retired) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before death) (State) Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Camp Springs		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5120 Clocton Avenue			
14. FATHER'S NAME First Clyde Middle Howard Last Sanger						15. MOTHER'S MAIDEN NAME First Dora Middle Henton Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO (If yes give war or dates of service)				17. INFORMANT Mr. Clyde W. Funkhouser (Son)				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 x x x												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ten days			
												unknown			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 1-7-68							
23a. BURIAL, CREMATION, REMOVAL (Specify) removal				23b. DATE 1/7/68				23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) McGaheysville, Va.			
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.								25a. REC'D BY REGISTRAR JAN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

jwb

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01421

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 9920 Franklin Ave. c. LENGTH OF STAY IN 1b 1 plus d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GlennDale Heights		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GlennDale Heights d. STREET ADDRESS 9920 Franklin Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hattie Virginia Gasch 4. DATE OF DEATH Jan 10 1968		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 21 Sept. 94 73 yrs. 9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John T. Ferguson 14. MOTHER'S MAIDEN NAME Emma Windsor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 218 38 8284 B 17. INFORMANT Elroy A. Gasch Address Same as # 2 Husband		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>bronchopneumonia</u> DUE TO (b) <u>arteriosclerotic heart disease and pulmonary disease</u> DUE TO (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to 1/10 1968, that (I) (we) last saw the deceased alive on 1/6 1968, and that death occurred at 4 PM, from the causes and on the date stated above. 22a. SIGNATURE H. James Kurtz 22c. PHYSICIAN'S NAME (Type) H. James Kurtz 22d. ADDRESS RFD Glenn Dale Md		22b. DATE SIGNED JAN 15 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/12/68 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION (City, town or county) (State) Colmar Manor Maryland		24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland 25a. REC'D BY REGISTRAR JAN 15 1968 25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

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01425

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01422

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
William Wallace Gibb						1 12 68						8:40 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	YEAR	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR			
male	white	3-15-02	65 YRS					Month 1 Day 12 Year 1968			11 P.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
									Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George's General			Retired			Marble Mason					
13a. USUAL RESIDENCE (Where deceased lived, if instit. on residence before admiss on) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Md.			P.G.			Bowie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Box 291 Hillmeade Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
William B Gibb			Ida Elizabeth Canter											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
yes			578 18 4209			Mary J Gibb			Bowie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure												minutes		
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease												unknown		
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), STATING THE UNDERLYING CAUSE LAST														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)														
4200														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED					
John Kohoe									1-13-68					
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)											
John Kohoe M.D., Riverdale, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			Jan 16, 1968			Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons			Hyattsville, Md.			DATE JAN 16 1968			Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

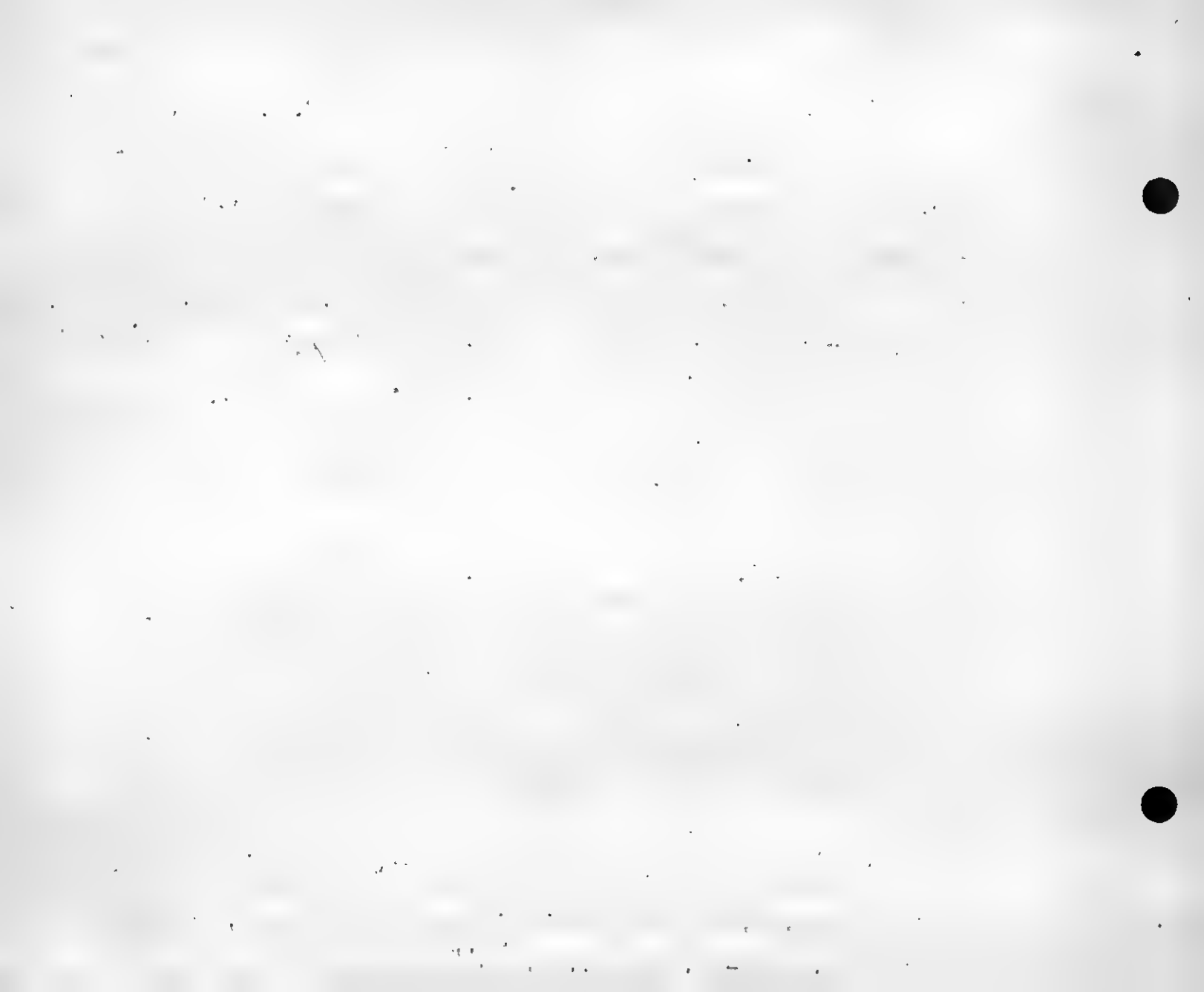
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01423

1. DECEASED-NAME (Type or print) Marie G Gibbons			2a. DATE OF DEATH Month January Day 25 Year 1968			2b. HOUR 9:00 M
3. SEX F	4 RACE White	5 DATE OF BIRTH 4/13/10		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS — DAYS — HOURS — MIN —
7a. BIRTHPLACE (State or foreign country) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.
10. CITY OR TOWN OF DEATH Riverdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ireland Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Prin. Georges		13c. CITY OR TOWN Oxenhill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER 6904 Livingston Rd.		14 FATHER'S NAME First Middle Last Deceased Joseph Edward CADELL		15. MOTHER'S MAIDEN NAME First Middle Last Deceased Nellie — GARRETT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO Worked Prior To This		17 INFORMANT Leonard Gibbons		Address s/a
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Uremia (b) Cirrhosis of Liver DUE TO, OR AS A CONSEQUENCE OF (c) —						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 week 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Re. Lungs Pneumonia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1966 , to JAN. 25, 1968 , that (I) (we) lost saw the deceased alive on January 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Walcutt W. Gibson M.D.				22c. DATE SIGNED January 25, 1968		22d. PHYSICIAN'S NAME (Type) Walcutt W. Gibson, M.D.
22e. ADDRESS 4300 St. Barnabas Road Marlow Heights, Maryland 20031						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 29, 68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS Wash., DC		25a. REC'D BY REG. STRAR JAN 30 1968		25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01430

01424

1 DECEASED NAME (Type or print) James		First	Middle B.	Last Gilbert	2a DATE OF DEATH Jan. Month 15 , Day 1968 Year		2b. HOUR p 11:45M	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH 28, 1908 March 22, 1909		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Md.		
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a USUAL OCCUPATION (Kind of work done during last work life, even if retired) Police Dept.		12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Capital Hgts.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 433 60th Avenue
14. FATHER'S NAME First Middle Last Chapman J. Gilbert				15. MOTHER'S MAIDEN NAME First Middle Last Estelle Belt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address Laurel, Md. Chapman Gilbert, Son, 21 Hillcrest Dr.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4-2-68								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Lung Cancer, Pneumonia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from 2:00 p.m. , 1968, to Jan. 15 , 1968, that (I) (we) last saw the deceased alive on Jan. 15 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.								
22b. SIGNATURE R. Deitz, M. D.						22c. DATE SIGNED Jan 16 1968		
22d. PHYSICIAN'S NAME (Type) R. Deitz, M. D.				22e. ADDRESS Prince Georges Plaza, Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/19/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR JAN 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

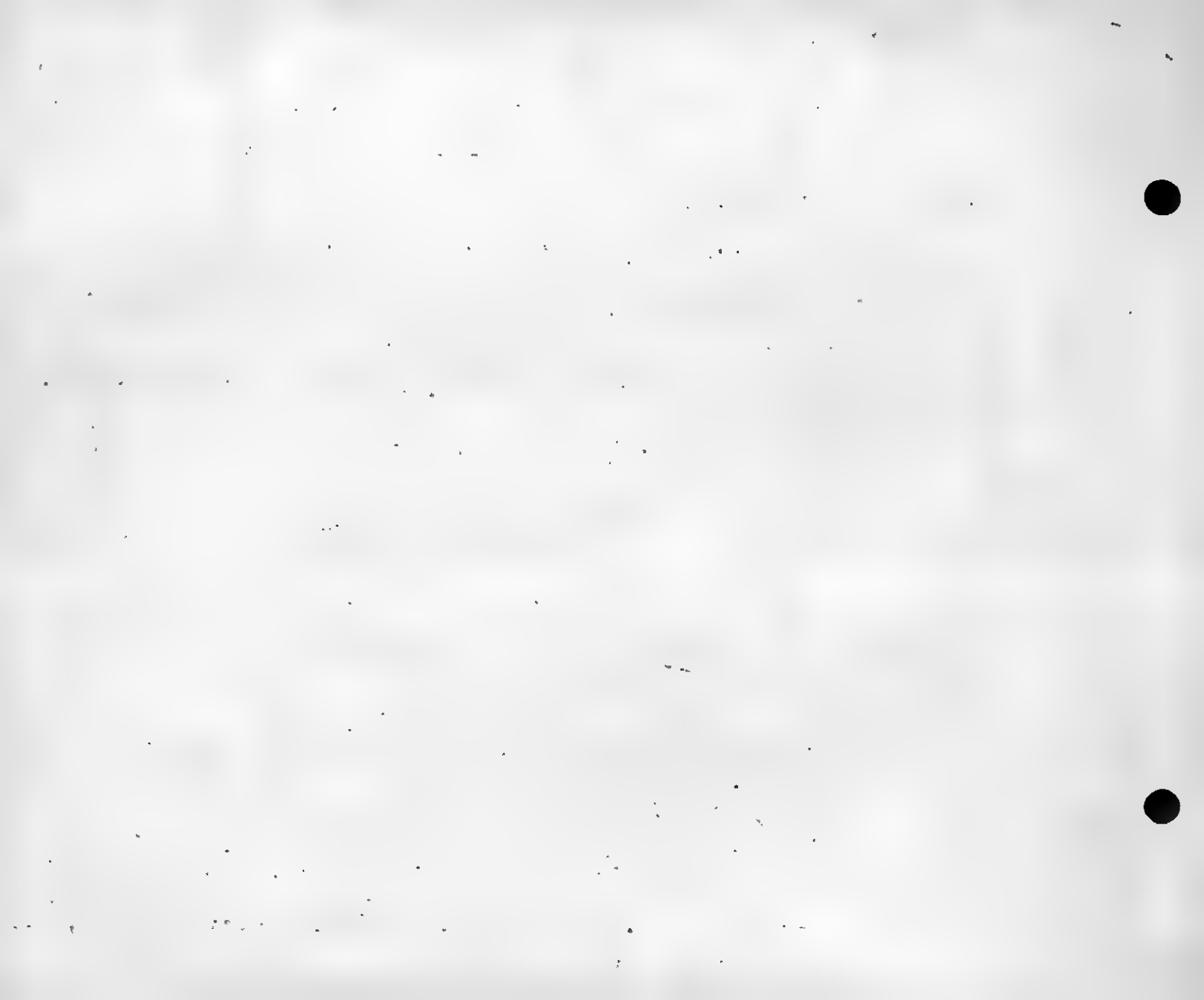
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Jessie May Good			2a. DATE OF DEATH Month Day Year Jan. 31 1968			2b. HOUR 5:25 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-29-1871		6. AGE (In years last birthday) 96 YRS	
7a. BIRTHPLACE (State or foreign country) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ---		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5320 Willard Ave.		14. FATHER'S NAME First Middle Last Thomas G. Good		15. MOTHER'S MAIDEN NAME First Middle Last Ada Hodgkin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b. SOCIAL SECURITY NO. 579-60-1124		17. INFORMANT Cousin Hazel V. Reynolds		18. ADDRESS Same as Item 13.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old healed pulmonary tuberculosis</u>	
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) ---		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) ---		21f. LOCATION Street or R.F.D. No. City or Town County State ---		22a. I certify that (I) (this hospital) attended the deceased from 5/15, 1963, to 1/31, 1968, that (I) (we) last saw the deceased alive on 1/25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE E. H. Aschenbach DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 2/1/68	
22d. PHYSICIAN'S NAME (Type) E. H. Aschenbach		22e. ADDRESS 1841 Col. Rd., N.W.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-3-68	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Prince George County, Md.		24. REGISTRAR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. RECD BY REGISTRAR FEB 6 1968	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. DATE FEB 6 1968		25d. REGISTRAR'S SIGNATURE [Signature]		25e. DATE FEB 6 1968	



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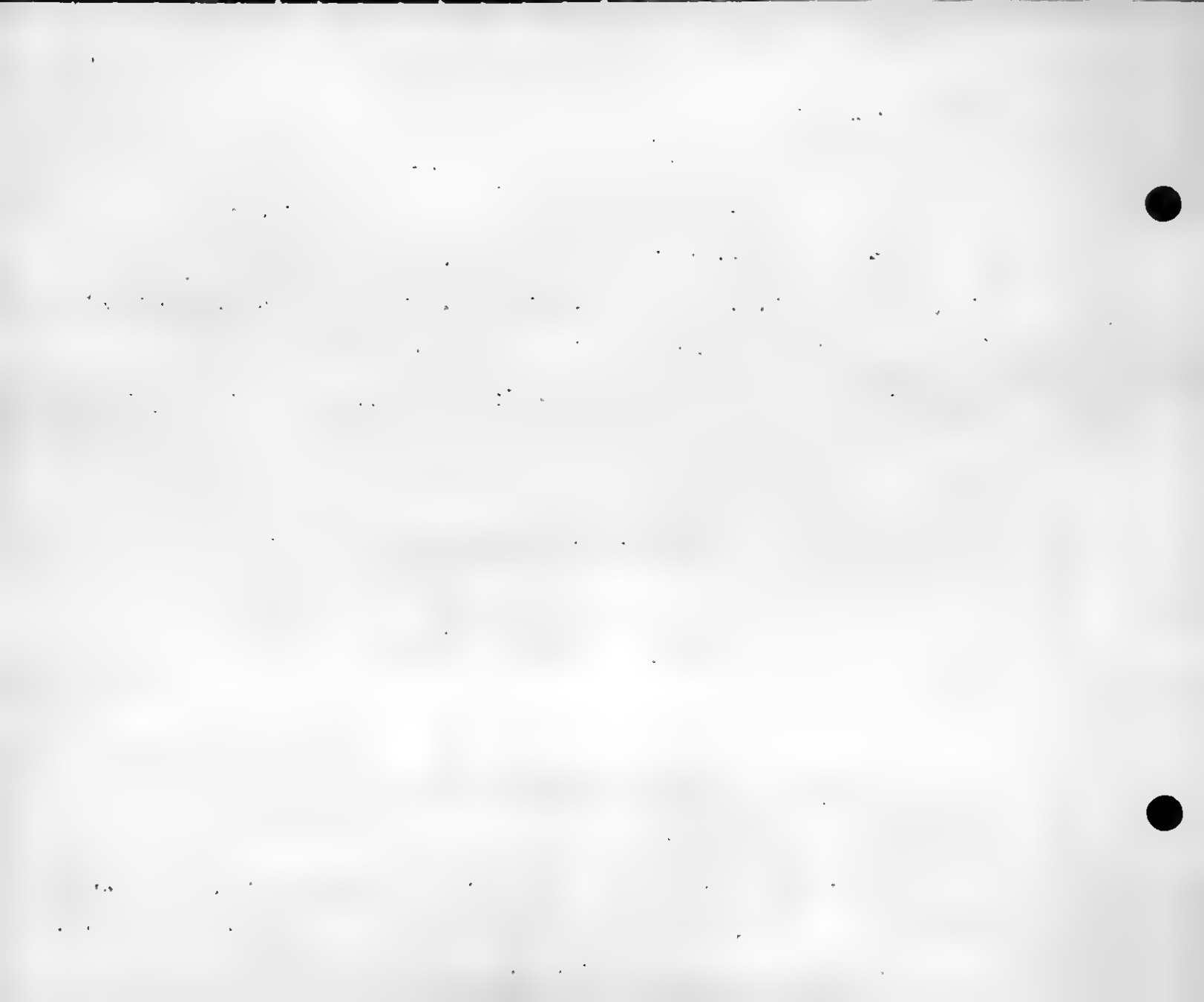
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CERTIFICATE OF DEATH

01432

01426

1. DECEASED NAME (Type or print) Hannah		First		Middle		Last		2a. DATE OF DEATH Month / Day 15 Year 68		2b. HOUR 12:30 AM	
3. SEX F		4. RACE N		5. DATE OF BIRTH 2/15/72				6. AGE (in years last birthday) 22 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY 1. C.		13c. CITY OR TOWN College Pk.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7506 Wellesley Drive			
14. FATHER'S NAME Samuel Korndaffer				15. MOTHER'S MAIDEN NAME Maria Garton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO.		17. INFORMANT Taken from previous admission.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4107 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July , 19 60 , to Jan , 19 67 , that (I) (we) last saw the deceased alive on 1-13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D. R. Purdie, M.D.		22c. DATE SIGNED 1-5-68		22d. PHYSICIAN'S NAME (Type) Dr. D. Purdie		22e. ADDRESS 4400 Queensbury Rd. Riverdale					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 17, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons		24b. ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



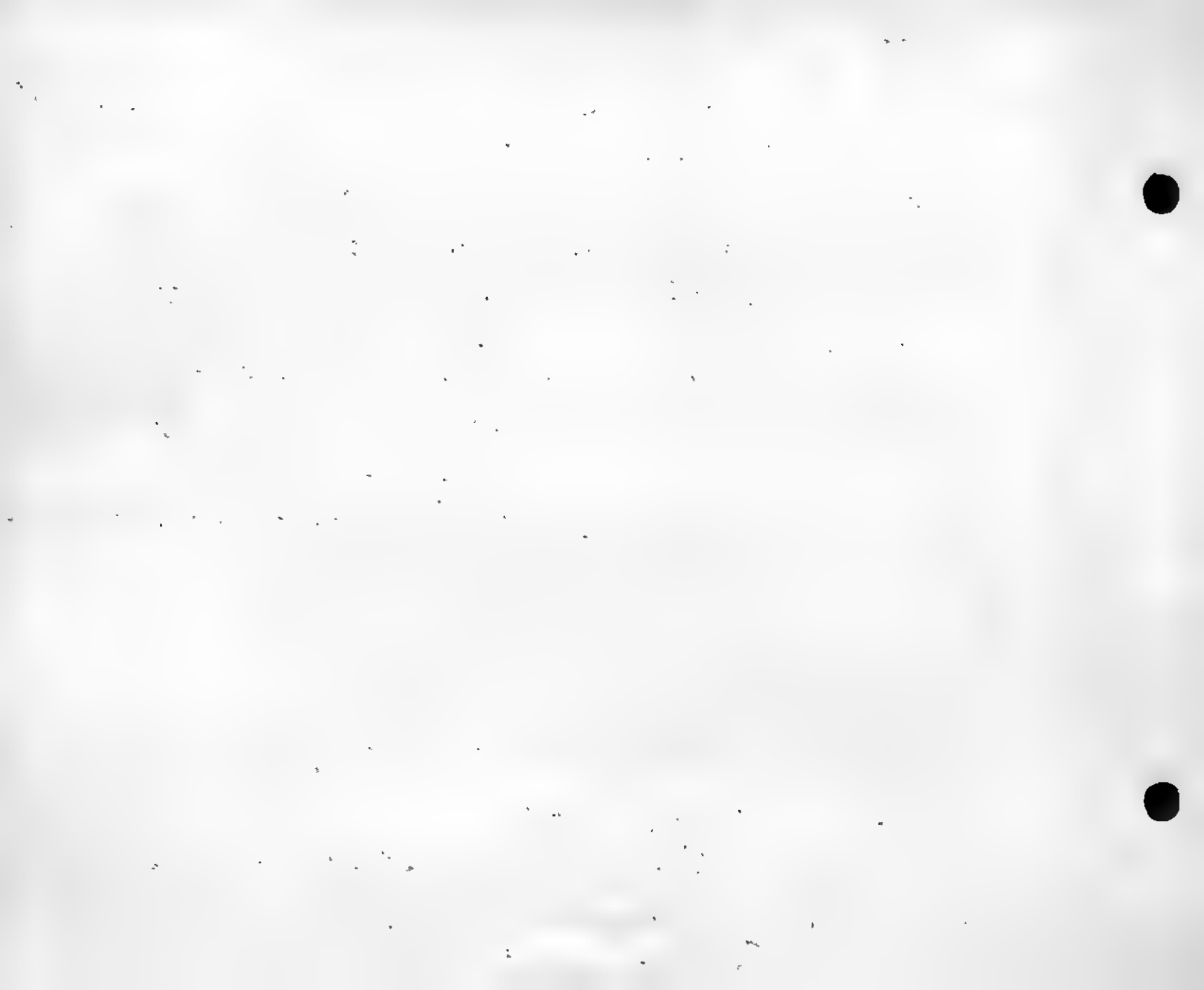
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) THOMAS A.G. GRABILL			2a. DATE OF DEATH Month JAN Day 11 Year 1968			2b. HOUR 7:35 P.M.					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH SEPT 15, 1911		6. AGE (in years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES Md.					
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE GEORGES GEN HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) GUARD			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN MT. RAINIER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4002 31st STREET		
14. FATHER'S NAME First Middle Last WILLIAM GRABILL			15. MOTHER'S MAIDEN NAME First Middle Last ANGIE LONG								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 578 072815		17. INFORMANT MRS MARGARET EVERETT Address 3018 NIAGARA RD COLLEGE PK. MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction sudden 11179 DUE TO, OR AS A CONSEQUENCE OF arterio sclerosis 1962 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) undetermined APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Aug 29, 1967 , to Jan 11, 1968 , that (I) (we) lost saw the deceased alive on Jan 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L W Melvin MD		22c. DATE SIGNED 1-12-68		22d. PHYSICIAN'S NAME (Type) L W Melvin MD		22e. ADDRESS Riverdale, Md.		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN 15, 1968		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON, NATIONAL		23d. LOCATION (City or Town) (County) (State) SOITLAND, MARYLAND		23e. REC'D BY REGISTRAR DATE JAN 18 1968		23f. REGISTRAR'S SIGNATURE John J. Judge	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD.											

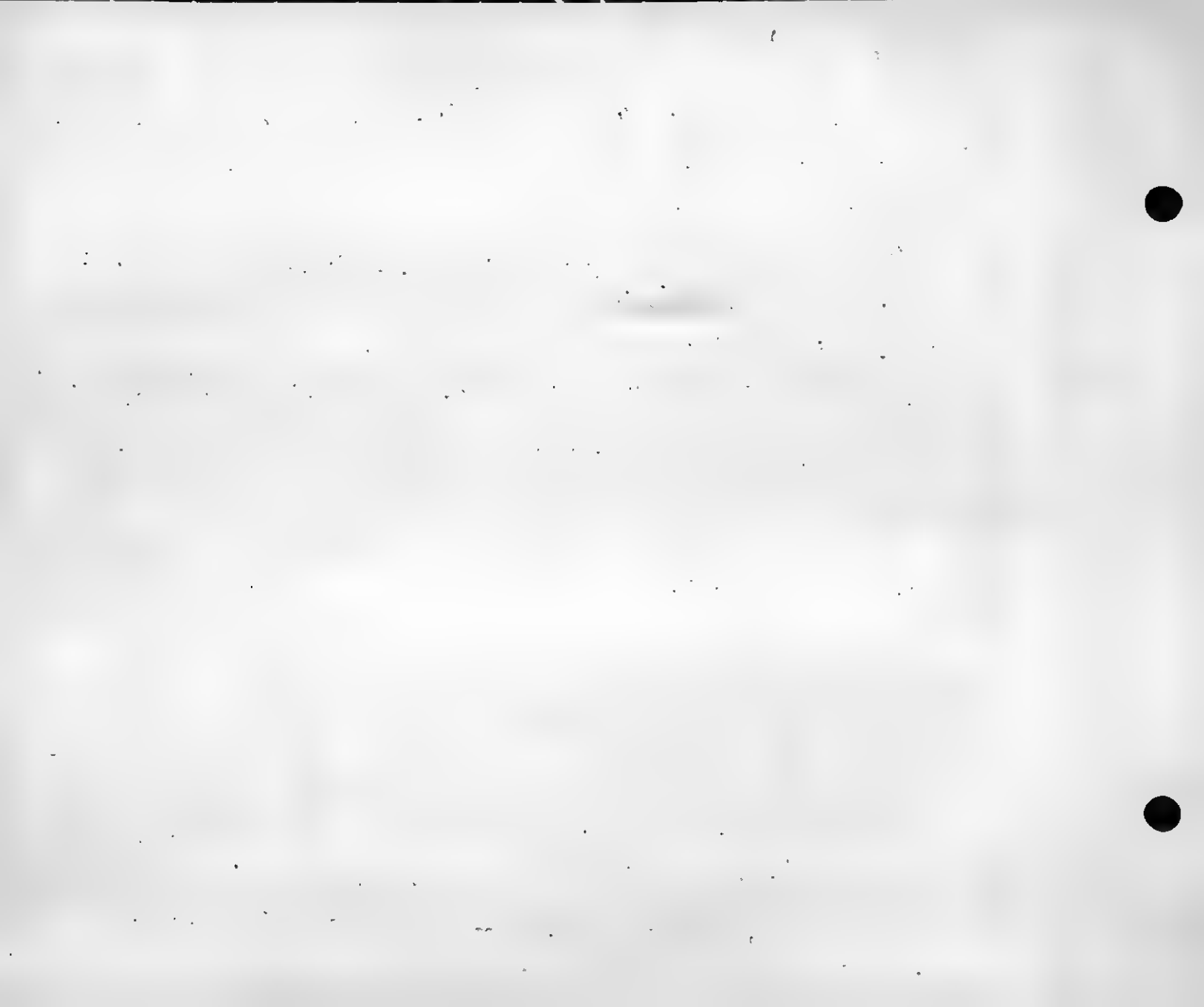


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VR A15
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) First <i>Daisy</i> Middle <i>Rebecca</i> Last <i>Graefe</i>					2a DATE OF DEATH Month <i>11</i> Day <i>11</i> Year <i>68</i>			2b HOUR <i>1P</i> M	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>5-14-85</i>		6 AGE (In years last birthday) <i>82</i> YRS.		7 IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>P. G. County</i> Md.			
10 CITY OR TOWN OF DEATH <i>Hyattsville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HYATTVILLE NURSING HOME</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b KIND OF BUSINESS OR INDUSTRY <i>HOME</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>PRO GEORGE</i>		13c CITY OR TOWN <i>BLADES BURG</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>4219-54th Place</i>	
14 FATHER'S NAME First <i>John F.</i> Middle <i>Alney</i> Last <i></i>				15 MOTHER'S MAIDEN NAME First <i>Mary A.</i> Middle <i>Knott</i> Last <i></i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b SOCIAL SECURITY NO <i>577-10-6892B</i>		17 INFORMANT <i>Charles L. Graefe</i>		17b ADDRESS <i>Bladensburg, Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>								<i>3 days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Central arteriosclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <i>1-10</i> , 19 <i>68</i> , to <i>1-11</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Donald C. Edgren, MD, DEGREE</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-11-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>DONALD C. EDGREN</i>				22e. ADDRESS <i>Hyattsville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 15, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Geo Md</i>			
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE <i>JAN 16 1968</i>					



CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) MARY E GREEN		2a. DATE OF DEATH Month JAN Day 4 Year 1968		2b. HOUR 9:25 M	
3. SEX F	4. RACE W	5. DATE OF BIRTH Nov. 10, 1877	6. AGE (In years last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Washington DC	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGES Md.		
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MADISON MANOR N.W.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington D.C.	13b. CITY OR TOWN Washington D.C.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4130 S. Dakota Ave. N.E.		
14. FATHER'S NAME First Archib Middle Thompson Last Gilcrest	15. MOTHER'S MAIDEN NAME First Mrs. Nellie V. Dietz same as above				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 215-54-5088	17. INFORMANT Mrs. Nellie V. Dietz same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 079.9 Hypertensive pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) viral infection pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 weeks 10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 096.9					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 8, 1967 , to Jan 4, 1968 , that (I) (we) last saw the deceased alive on Jan 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard F Shaw MD DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 1-4-68			
22d. PHYSICIAN'S NAME (Type) DR. RICHARD F SHAW	22e. ADDRESS 1324 - Michigan Ave NE				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 1/6/68	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.		
24. FUNERAL DIRECTOR The S. H. Hines Co.	ADDRESS Washington, D.C.	25a. REC'D BY REGISTRAR DATE JAN 8 1968	25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01436

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01430

1. DECEASED-NAME (Type or print) Sophie		First Middle Last		2a. DATE OF DEATH Jan. Month 19 , Day 1968 Year		2b. HOUR 11:05 A	
3. SEX Female		4. RACE Negroid		5. DATE OF BIRTH Feb. 28, 1888		6. AGE (In years last birthday) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Capitol Hgts.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Edward		First Middle Last Gross		15. MOTHER'S MAIDEN NAME Sarah		First Middle Last Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 212-56-0531		17. INFORMANT Mary Carrol 60 48 Capital Heigh Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 481X IMMEDIATE CAUSE (a) Pneumonia, right upper lobe, severe. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 470X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that he (this hospital) attended the deceased from Dec. 25, 1967 , to Jan. 19, 1968 , that he (we) last saw the deceased alive on Jan. 19, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) not view the body after death.							
22b. SIGNATURE Frederick H. Wilhelm				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/19/68	
22d. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M. D.				22e. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-24-68		23c. NAME OF CEMETERY OR CREMATORY St. Edmund Ch. Cem		23d. LOCATION (City or Town) (County) (State) Sunderland Cal Md	
24. FUNERAL DIRECTOR Pinkney E. Seewell				ADDRESS Prince Georges Gen. Hosp.		25a. REC'D BY REGISTRAR DATE JAN 26 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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01-130

NAME	DATE	TIME	LOCATION
John Doe	Jan. 15, 1945	10:00	Room 101
Jane Smith	Jan. 15, 1945	11:00	Room 102
Robert Brown	Jan. 15, 1945	12:00	Room 103
Mary White	Jan. 15, 1945	13:00	Room 104
James Green	Jan. 15, 1945	14:00	Room 105
Elizabeth Black	Jan. 15, 1945	15:00	Room 106
William Grey	Jan. 15, 1945	16:00	Room 107
Patricia Blue	Jan. 15, 1945	17:00	Room 108
Richard Gold	Jan. 15, 1945	18:00	Room 109
Susan Silver	Jan. 15, 1945	19:00	Room 110

Handwritten notes and signatures at the bottom of the page, including a large signature that appears to read "John Doe" and some illegible text.